



# FLORIDA CARDIAC CONSULTANTS, INC.

## MEDICAL RECORDS RELEASE AUTHORIZATION PLEASE READ AND COMPLETE THE ENTIRE FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize Florida Cardiac Consultants to: (check one)

SEND my records to:  OBTAIN my records from:

\_\_\_\_\_  
Name of Physician or Facility

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

For the purpose of: (check one)

Continued Care  Personal Use  New Patient Appt. on: \_\_\_\_\_

Legal  Disability Claim  Other

LIST SPECIFICALLY THE INFORMATION TO BE RELEASED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that my medical records may contain information about drug and/or drug treatment, mental health or behavioral health treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information as specified for the purpose of need as indicated above. I understand that Florida Cardiac Consultants may utilize a medical record correspondence service and that there may be a fee assessed for that service. I understand that I may revoke this authorization, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire one year after the date signed. A photocopy or fax of this authorization shall have the same effect as the original.

\_\_\_\_\_  
Signature of Patient or Legal Rep.

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**Medical Records Fax: Sarasota 941-316-9305 Venice 941-484-5928**