

BRADENTON CARDIOLOGY CENTER

316 Manatee Avenue West, Bradenton, FL 34205, Phone: (941) 748-2277

FAX: (941) 748-4244

AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I WOULD LIKE TO PICK UP _____ (Id required) Verified: _____
PLEASE MAIL _____ FAX _____

Medical Record Number _____

Last Name: _____, First Name: _____ Middle Initial: _____
Date of Birth: _____ SS# _____ Phone # _____

Give the complete names and addresses of the medical facility or organization you are authorizing your medical records to be released to or from:

I hereby authorize:
(Name and address of releasing facility)

To Release Information to:
(Individual name, facility/organization and address)

Phone: _____ Fax: _____

Phone: _____ Fax: _____

OFFICE USE: Fax # verified Yes _____ No _____

TYPE OF INFORMATION TO BE RELEASED:

Please initial **each** applicable area in order to authorize release.

1. _____ All records from _____ to _____
2. _____ Test results, specific test _____
3. _____ Other, please specify exact information _____
4. _____ Mental Health/Substance Abuse/HIV related information. **Patient signature required** _____
Date _____

INFORMATION TO BE RELEASED FOR THE PURPOSE OF:

Continuing Care _____ Insurance Claim Other (Please describe) _____

Transfer of Care _____ Personal Copy

Disability Determination _____ Legal Claim

ACKNOWLEDGEMENT OF UNDERSTANDING:

- ✓ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- ✓ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- ✓ I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

Signature of patient or legal representative

Date