BRADENTON HEART CENTER

2010 59th St, West Bradenton, FL 34209 (941)794-3999
FAX: (941)792-4048

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)

_____
_____
_____
_____

Phone:_____Fax:_____

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

_____
_____
_____
_____

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.

_____ Date_____
Signature of patient or legal representative