HEART CARE CENTERS
OF FLORIDA

Authorization to Release Health Information

Patient Name: _____

Date of birth: _____ Phone: _____

Address: _____

Covering the period of healthcare from _____ to _____

Information to be disclosed

__ History & Physical __ Consultation Reports __ Summary

__ Progress notes __ Physician orders __ EKG

__ Complete Health __ Lab and X-rays __ Other

If applicable, I also give permission for the following to be disclosed (please initial)

__ Acquired Immunodeficiency syndrome (AIDS) or infected with Human immunodeficiency Virus. (HIV)

__ Behavioral Health Services/Psychiatric care

__ Treatment for Alcohol and or drug abuse

Please release to: Heart Care Center Of Florida

3822 S. Washington Ave. / (Heart Care CFL, P.A.)

Titusville, FL. 32780

Phone: 321-636-6914

Fax: 321-636-6916

I understand that I have the right to revoke this at any time. This authorization will expire in 90 days.

I understand that any disclosure of information carries with it potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, then contact the privacy office at the number above.

Patients Signature _____ Date_____

Witness _____ Date _____