



**Cardiovascular Institute of Central Florida  
Authorization for Use of Disclosure of Protected Health Information  
Health Information Management Department**

**PLEASE PRINT**

PATIENT NAME: \_\_\_\_\_ SS: XXX-XX- \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PHONE: \_\_\_\_\_

Send Information to: (print name of person, organization or agency with full address of where records are being sent.)

Name: \_\_\_\_\_ Fax: \_\_\_\_\_

ATTENTION MEDICAL RECORDS Phone: \_\_\_\_\_

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

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

Purpose of Release (Continued Care, Personal, etc.):

Specific Items Needed:  Consults  Stress Test  Holter Monitor  Echo  
 LEA  Carotid  EKG  Other

Specific Dates Needed: \_\_\_\_\_

PLEASE NOTE: AS A GENERAL RULE, WE ONLY COPY AND RELEASE RECORDS GENERATED BY THIS FACILITY. THERE MAY BE A FEE CHARGED AS ALLOWABLE BY FLORIDA LAW.

**TO THE PATIENT**

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination. As required by state and federal law, Cardiovascular Institute of Central Florida may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorizations, but that Cardiovascular Institute of Central Florida cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition. I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Health Information Management, Cardiovascular Institute of Central Florida, 2111 SW 20th Place, Ocala, FL 34471. I further understand that any such revocation does not apply to the information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization. I hereby release Cardiovascular Institute of Central Florida and all employees from any and all liability that may arise from the release of information as I have directed.

I hereby authorize Cardiovascular Institute of Central Florida to release information as described above.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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