CVI
Cardiovascular Institute of Central Florida

- ☐ Dr. Shafeeq Ahmed, MD
- ☐ Dr. Ramil Goel, MD
- ☐ Dr. Siva Gummadi, MD, FACC
- ☐ Dr. Vijaya Koka, MD, FACC
- ☐ Dr. Jayanth Koneru, MD
- ☐ Dr. Hima Mikkilineni, MD, FACC
- ☐ Dr. Jigar Patel, MD
- ☐ Dr. Srisha Rao, MD, FACC
- ☐ Dr. Prem Singh, MD, FACC, FSCAI
- ☐ Dr. Paul Urban, MD, FACC, FSCAI

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

PLEASE PRINT

TO:
RECORD CUSTODIAN AT: _____

ATTENTION: _____ PHONE: _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RE: PATIENT'S NAME: _____ DOB: _____ SS: XXX-XX- _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SEND INFORMATION TO: CARDIOVASCULAR INSTITUTE OF CENTRAL FLORIDA
2111 SW 20TH PLACE, OCALA FL 34471

ATTN: _____

PHONE: 352-622-4251 EXT: _____ FAX: _____

PURPOSE OF RELEASE (Continued Care, Personal, etc.):

SPECIFIC ITEMS NEEDED:
☐ Consults ☐ Stress Test ☐ Holter Monitor ☐ Echo
☐ LAB ☐ LEA ☐ Carotid ☐ EKG

OTHER: _____

HOSPITAL RECORDS: ☐ H&P ☐ Op Rpt ☐ Cardiac Cath ☐ Consults ☐ Discharge

SPECIFIC DATES NEEDED: _____

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: _____