**Authorization For Release Of Medical Information**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_ authorize **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (“Provider”) of Cardiac and Vascular Consultants, to disclose protected health information (“PHI”) regarding:

Patient Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_, Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the PHI be disclosed at my individual request to **Cardiac and Vascular Consultants** at the following location:

\_\_\_ Creekside Medical Plaza 1050 Old Camp Road Ste. 270 The Villages, FL 32162 Ph: 352-633-1966\* Fax: 352-633-1969

\_\_\_ Conard Plaza 4224 West Gulf To Lake Highway, Lecanto, FL 34461\* Ph: 352-513-3482\*Fax: 352-513-3489

**Check One:**

I authorize the following PHI to be released:

\_\_All health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information good for **one year** of the date signed.

\_\_For a **limited time period beginning\_\_\_\_\_\_\_\_\_\_\_\_ and ending\_\_\_\_\_\_\_\_\_\_\_\_** all health information about the patient in the possession of Provider, including, but not limited to psychiatric ,mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information.

\_\_Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed **(ii):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_Other, as described here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Release to:**

|  |  |
| --- | --- |
| **Name of Organization/Person** |  |
| **Address of Organization:** |  |
| **Phone Number :** | **Fax Number:** |

1. Psychotherapy notes are notes by a mental health professional documenting private counseling stored separately from the chart. To release them requires a separate release.
2. The Provider is authorized by law to use or disclose PHI for a variety of reasons without the patient’s authorization. Please see the Provider’s Notice of Privacy Practice for details.

This Authorization was developed to comply with the Health Insurance Portability and Accountability Act (HIPPA) of 1996, the health Information Technology for Economic and Clinical Health (HITECH) Act, the American Recovery and Reinvestment Act (ARRA) of 2009 and associated regulations.

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**Signature of Patient or Legal Representative Date Witness Signature Date**