

RECORDS RELEASE AUTHORIZATION

Name of Practice: DAYTONA HEART GROUP
695 N Clyde Morris Blvd
Daytona Beach FL 32114

Phone #: 386-258-8722
Fax #: 386-258-9443

Patient name: _____ Date of birth: _____

I. My Authorization

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmissible diseases.

Records we need: _____

You may disclose this health information TO:

Name (or title) and organization _____
Address: _____
Phone #: _____ Fax #: _____

You may disclose this health information FROM:

Name (or title) and organization _____
Address: _____
Phone #: _____ Fax #: _____

Purpose of release (For example: continued care, personal, etc): _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

However, I do have to sign an authorization form:

- To take part in a research study. Or
- To receive health care when the purpose is to create health information for a third party.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office, or
- Write a letter to the office

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)