

**Tampa Cardiovascular Associates**

**Vasco M. Marques, M.D., F.A.C.C.**

**Asad Sawar, M.D., F.A.C.C.**

**Victor Feliz, M.D., F.A.C.C.**

**3010 East 138<sup>th</sup> Avenue, Suite 12**

**Tampa, Florida 33613**

**Phone: 813-975-2800 Fax: 813-977-7924**

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Patient's Name \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**A) REQUEST FOR RECORDS TO BE SENT TO TAMPA CARDIOVASCULAR ASSOCIATES:**

I hereby authorize \_\_\_\_\_  
\_\_\_\_\_

To disclose my Protected Health Information to: Tampa Cardiovascular Associates  
**Fax: 813-977-7924**

**B) REQUEST FOR TAMPA CARDIOVASCULAR ASSOCIATES TO SEND RECORDS:**

I hereby authorize Tampa Cardiovascular Associates to disclose my Protected Health information to the following organization and/or person:

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I agree that a copy or fax of this release shall be as valid as this original release. I authorize Tampa Cardiovascular Associates to fax the information. I realize there are inherent risks in faxing Protected Health Information.

This authorization expires on \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

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