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 138th 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

updated 5/25/18