

Tampa Cardiovascular Associates, P.A.
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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