AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Tri County HEART INSTITUTE
Dr. Nitza I Alvarez

1400 US HWY 441 North Suite 537 The Villages FL 32159
Off:352-504-3500 Fax352-504-3388

NAME OF PATIENT			
DATE OF BIRTH		SS#	

RECORDS WILL BE DISCLOSED TO:						
Name	Tri-County Heart Institute PA			Phone	352-504-3500	
Address	1400 US HWY 441 North Suite 537			Fax	352-504-3388	
City/State Zip	City	The Villages	State	Florida	Zip	32159

For the Following Purposes:

X	Continuity of Care		Personal Information		Legal (To Attorney/Court)
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

X	**Please send the entire Medical Record (all information) to the above named recipient.**				
	Office Notes and Reports		Diagnostic Reports		Billing Statements
	Rx History		Transcribed Hospital Reports		Laboratory Reports
	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
_____ Mental Health Information and/or Records
_____ Domestic Violence
_____ Genetic Testing Information and/or records
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified above:

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____

Identity of Requestor Verified: ☐ Photo ID ☐ Matching ID ☐ Other: _____