Palm Coast Cardiovascular Institute

Authorization to Release Medical Information

Patient Name:_____ Social Security Number:_____

Date of Birth:_____ Patient Signature:_____

I AUTHORIZE: TO RELEASE TO:

Palm Coast Cardiovascular Institute _____

19 Old Kings Road Suite C106 _____

Palm Coast, FL 32137 _____

INFORMATION TO BE RELEASED: _____

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By signing below, you are authorizing the office to release any and all information regarding:

___ Alcohol ___Drugs ___Mental Health ___Sexually Transmitted Disease ___HIV ___AIDS

Signature: _____

If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from the records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressed permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any drug abuse patient.

RECORDS FROM THE PERIOD: ____/____/_____ to ____/____/____

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

Continued Medical Care Payment of Insurance Claim Other:_____

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

The requestor may be provided with a copy of this authorization.

Telephone: 386-446-6540 Fax: 386-447-7732