HEART SPECIALISTS OF SARASOTA

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Daniel L. Molloy, MD
Thomas P. Archer, MD
Matthew Johnson, PA-C
Andrea Haynie, ARNP

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

PATIENT:

_____ _____
Name of Patient/Previous Names | Birth Date/Social Security Number

_____ _____
Street Address | City, State, Zip

_____
Telephone Number

AUTHORIZES:

Heart Specialists of Sarasota
1950 Arlington St.
Suite 400
Sarasota, FL 34239
Phone: 941-917-4250
Fax: 941-917-4257

RELEASE OF PROTECTED HEALTH INFORMATION TO:

_____
Name of Health Care Provider

_____
Street Address

_____
City, State, Zip
Phone or Fax:

INFORMATION TO BE RELEASED:

I hereby authorize you to release **all** of my medical records for any treatment and laboratory/diagnostic tests performed **except for**:

___Sexually Transmitted Disease
___HIV (AIDS)
___Alcohol Abuse Treatment
___Drug Abuse Treatment
___ Mental Health Treatment
___ Records from other facilities and providers

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (check one)

___ Further Medical Care
___ Insurance/Eligibility
___ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Heart Specialists of Sarasota will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Heart Specialists of Sarasota will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

SIGNATURE PATIENT/LEGAL REP: _____DATE: _____

(If signed by other than patient, state relationship and authority to do so.)

EXPIRATION DATE: This authorization is good until the following date(s)_____or for twelve (12) months from the date signed. Distribution of copies: Original to provider; copy to patient; copy to accompany released records

REV. 07/16