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**AUTHORIZATION TO RELEASE OR
FAX PATIENT INFORMATION**

I authorize the use or disclosure of my individually identifiable health information as described below.

Patient Name: _____ (Print Name) Medical Record Number: _____
Address: _____ SS#: _____
_____ DOB: _____

This Authorizes:	To Release To:	<u>RELEASE BY:</u>
_____ (Name)	_____ (Name)	MAIL FAX
_____ (Address)	_____ (Address)	(CIRCLE ONE)
_____ (City, State, Zip)	_____ (City, State, Zip)	

NOTE: Faxing of Health Information is ONLY for Patient Care, Hospital and Physician Offices

Description of Information to be Released: _____

(Please circle one)
Reason for Release: **Continuing Care** **Insurance** **Personal** **Attorney**

Please Fax my Health Information to this number: _____

I understand that: My treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this authorization.

Any alcohol or drug abuse information released is protected by Federal Regulations and may not be re-disclosed without the specific written consent of the undersigned. Any psychiatric information, HIV and AIDS-related testing or results, and STD information released is similarly protected from re-disclosure by Florida Statute.

Warning: Information released (pursuant to this authorization) to organizations not defined as "Covered Entities" by HHS may be at risk for re-disclosure by that entity during the course of their business activities. This re-disclosure is not protected by the HIPAA Privacy Rule, as HHS has no authority to oversee their activity.

This release is valid for 90 days or unless revoked by patient before the information has been released. I may obtain and complete a "Request to Revoke Authorization" form from The Heart Group Health Information department as referenced in the Notice of Privacy Practices.

PATIENT SIGNATURE: _____ DATE: _____
(OR LEGAL REPRESENTATIVE, MUST ATTACH COPY OF "POWER OF ATTORNEY")