The Heart & Vascular Center OF SARASOTA

1217 S. East Ave, Suite 104, Sarasota, FL 34239
WWW.HEARTCENTER.COM

Authorization to Use and Disclose Health Information

Please Read and Complete the Entire Form.

Patient Name:_____ **Patient Address:**_____
Date of Birth:_____ _____
Social Security:_____ **Home Phone No.:**_____
Email:_____ **Cell Phone No.:**_____

I authorize the Heart & Vascular Center of Sarasota to use and disclose a copy of the specific health and medical information described below:

( ) Send my records to: ( ) Obtain my records from:

_____
Name of Physician or Facility

_____
Complete Street Address City State Zip Code

_____
Telephone/Fax No.

Purpose: ( ) Continued Medical Care ( ) Personal Use ( ) New Patient Appt. on: _____

List specifically the information to be released:

_____

_____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and,
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request. A photocopy of this authorization shall have the same affect as the original.

I understand that my record may contain information about alcohol and/or drug treatment, mental health or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above.

I understand the Heart & Vascular Center of Sarasota may utilize a medical records correspondence service and that there may be a fee assessed for this service.

PLEASE ALLOW 7 TO 10 BUSINESS DAYS FOR RECORDS TO BE COPIED.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Signature of Patient/Legal Representative	Relationship to Patient	Date

COST OF REPRODUCING MEDICAL RECORDS

64B8-10.003 Costs of Reproducing Medical Records:

1. Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records
2. Reasonable cost of reproducing copies of written or typed documents or reports shall not be more that the following:
    a) For the first 25 pages, the cost shall be $1.00 per page.
    b) For each page in excess of 25 pages, the cost shall be 25 cents.
3. Reasonable costs of reproducing X-rays, and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication.

The Heart &Vascular Center Of Sarasota * Ph: 941-365-0433 * Fax: 941-954-2064

Credit(s):
Specific Authority 458.309 FS. Law Implemented 455.674, 455.677, 458.331(1) FS. History – New 11/17/87, Amended 5/12/88, Formerly 21M-26.003, 61f6-26.003, 59r-10.003.