FLORIDA CARDIOLOGY, P.A.
Dedicated • Compassionate • Convenient
www.flcard.com

## HIPAA Release of information-Authorization Form

I, _____, hereby authorize Florida Cardiology, P.A. and its affiliates to: **(check those that apply)**

☐ **Obtain and use the following protected health information**

☐ **Disclose the following protected health information (include Providers full name, address, telephone and fax number, if applicable)**

_____

_____

Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

_____

_____

**This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations for the purpose of continuity care.**

**This authorization is valid from the date of my/my representative's signature below and shall be in force and effect until** _____at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Florida Cardiology, P.A office location where my records are managed.

*I understand that a revocation is not effective to the extent that Florida Cardiology, P.A. has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal of state law. Florida Cardiology, P.A. will not condition my treatment, payment, enrollment, (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use of disclosure.*

***I understand that I have the right to refuse to sign this authorization.***

**Signature of Patient** **Date of Birth**

**Name of Employee Witness** **Date:**

*If applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patients behalf with respect to this authorization form.*

**Personal Representative** **Description of Personal Representative's**


**ALOMA**
483 N. Semoran Blvd., Suite 102-Winter Park, FL 32792
(407) 645-1847 – Fax (321) 274-0246

**METROWEST**
6200 Metrowest Blvd., Suite 102-Orlando, FL 32835
(407) 294-5551 – Fax (407) 294-5572

**LAKE UNDER HILL**
7806 Lake Under Hill Rd.-Orlando, FL 32337
(407) 601-0888 – Fax (407) 601-0931

**CLERMONT**
255 Citrus Tower Blvd., Suite 101-Clermont, FL 34711
(352) 394-0893 – Fax (352) 243-1188

**DAVENPORT**
2239 North Blvd. West-Davenport, FL 33837
(863) 419-1418 – Fax (863) 419-1809

**APOPKA**
201 North Park Ave-Apopka, FL 32703
(407) 410-5000 – Fax (407) 410-5008

**OVIEDO**
7440 Red Bug Lake Road-Oviedo, FL 32765
(407) 971-0000 – Fax (407) 971-0008

**HUNTERS CREEK**
14501 Gatorland Drive-Orlando, FL 32837
(407) 931-0070 – Fax (407) 816-4174

**LONGWOOD**
515 West SR 434, Suite 301-Longwood, FL 32750
(407) 755-4018 – Fax (407) 755-4107