ORLANDO HEALTH | Heart Institute
Cardiology Group

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

There is a charge for copying your records, due at time of service or before records will be mailed or faxed. The charge is $1.00 per page for the first 25 pages and $0.25 per page thereafter for both electronic and paper requests. Please make checks payable to Orlando Health. Records sent to another treating physician will be faxed at no charge.

Patient Name: _____ Date of Birth: _____

Address: _____

The above named patient authorizes Orlando Health Heart Institute Cardiology Group:

OBTAIN RECORDS FROM ☐ / RELEASE TO ☐ (**Check one only**) health information to/from:

Name: _____

Address: _____

Phone: _____ Fax: _____

The following information that may contain information related to HIV/AIDS, sexually transmitted diseases, mental health (excluding psychotherapy notes – a separate authorization is required), **alcohol or substance abuse and genetic testing unless otherwise restricted by me.**

☐ **All records**	☐ **EKG**	☐ **Operative Report**
☐ **Office notes**	☐ **CXR Report**	☐ **DC Summary**
☐ **H/P or Consultation**	☐ **Non-invasive Tests**	☐ **Other:** _____
☐ **Labs**	☐ **Invasive Tests**	

I would like to receive my records in (**Check one only**): ☐ Paper format ☐ Electronic format

Purpose of Disclosure: ☐ Insurance ☐ Legal ☐ Continued Treatment ☐ Personal Use

☐ Patient communication (Behavioral Health) ☐ Other (Please Specify):_____

By signing this authorization form, I authorize the use and disclosure of my health information. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for health care benefits. I have signed this form voluntarily in order to document my wishes regarding the use and disclosure of my health information. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed.

The authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that a photocopy or fax of this authorization is as valid as this original.

_____ _____
Signature of Patient or Personal Representative Date

_____
Personal Representative's Authority (if applicable)

_____ _____
Completed/faxed by Date

Orlando Health Heart Institute Cardiology Group
1222 South Orange Avenue, MP 804
Orlando, FL 32806
321-841-OHHI (6444)
Fax: 407-650-1307