TAMPA CARDIAC SPECIALISTS

MEDICAL RECORDS REQUEST

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____
(Last) (First) (Middle Inital) (Maiden/Other)

Date of Birth: _____/_____/_____ SSN#: _____
(Month) (Day) (Year)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____

I authorize Tampa Cardiac Specialists to:
CHOOSE ONE ONLY □Send/disclose health information to □ Receive/request health information from

□Patient

Doctor's Name or Facility _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ Fax: _____

CHOOSE ONE ONLY □ To be picked up □ To be mailed □ To be faxed
The following medical record report(s) for services are to be released (check all applicable):

□All Records □Other (please specify): _____

For the purpose of:
□ Personal Use □Continuing Medical Care □Payment/Insurance □Other: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
(Signature of Patient or Personal Representative) (Date of Request)

_____
(Printed Name of Patient or Personal Representative)

_____ _____
(Witness) (Date)

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