# Florida Cardiology, P.A.

483 N. Semoran Blvd. Ste. 102
Winter Park, Fl. 32792
(407) 645-1847
Fax (321) 274 - 0246

## Authorization for Use or Disclosure of Information

I, ______________________________________, hereby authorize Florida Cardiology, PA to (check those that apply):

__ obtain / use the following protected health information from, and/or

__ disclose the following protected health information to:

_______________________________________________________________________________

(Please include Dr's. full name, address, telephone and fax number, if applicable)

_______________________________________________________________________________

Specifically describe the information to be used or 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 for the following purposes:

_______________________________________________________________________________

This authorization shall be in force and effect until ____________________________________________

*Date or event that relates to the purpose of the disclosure*

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 Office Manager of Florida Cardiology, PA. at 483 N. Semoran Blvd. #102, Winter Park, FL 32792. I understand that a revocation is not effective to the extent that Florida Cardiology, PA. 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 redisclosure by the recipient and may no longer be protected by federal or state law. Florida Cardiology, PA. will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

______________________________________

Signature of Patient or Personal Representative

______________________________________

Signature of Witness

______________________________________

Social Security #

______________________________________

Patient Date Of Birth

______________________________________

Name of Patient or Personal Representative

______________________________________

Date

______________________________________

Description of Personal Representative's Authority