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Authorization to Disclose Health Information

Patient Name: _____

DOB: _____ SSN: _____

Address: _____

City: _____ FL. Zip: _____

I authorize and request Space Coast Vascular to RELEASE Medical Records to:

Person or Organization: _____

Phone: _____ Fax: _____

Purpose of Request: Personal Treatment Legal Insurance Disability

Transfer/ Reason _____ Other _____

I authorize and request Space Coast Vascular to OBTAIN Medical Records from:

Organization: _____

Phone: _____ Fax: _____

Please: Fax Mail the following information from my medical record for care and/or treatment:

Office and Progress Notes Procedure/ Surgery Reports Imaging Studies

Diagnostic Studies Lab/bloodwork Other: _____

From the time period of _____ thru _____ / present.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by MAB and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.
- I understand that the health record may include information relating to sexually transmitted disease, acquired Immuno-deficiency syndrome (AIDS) or human immune-deficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that this authorization will remain in effect for 90 DAYS or until I revoke it in writing to the Health Information Management Dept.
- I understand that I may inspect or copy the information that is used or disclosed.

Patient Signature: _____ **Date:** _____

(Required for all patients 18 yrs and older. 18 yrs and older for psychiatric records, 14 yrs and older for substance use records)

Signature of Parent or Legal Guardian: _____ **Date:** _____

(Required for all patients under age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)