**David M. Yamada, MD, FACC, FSCAI David Schreibman, MD, FACC**

**Michael Mollod, MD, FACC Steven J. Class, MD, FACC**

**Thomas W. Archer, MD, FACC Robert E. Eckart, DO, FACC, FHRS**

**Chippy Ajithan, MD, FACC Brian P. Betensky, M.D., FACC**

**Garrett H Brown, MD Daniel L. Molloy, MD**

**Anthony W. D’Souza, MD Evan M. Caruso, MD**

**V. Grant Luce, PA-C Keith Sieracki, PA-C**

**Matthew Johnson, PA-C Andrea Hayine, ARNP**

**Martin Kent, PA**

 **AUTHORIZATION TO OBTAIN MEDICAL RECORDS**

**PATIENT:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Patient/Previous Names Birth Date/Social Security Number

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Street Address City, State, Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Telephone Number

## AUTHORIZES: OBTAIN PROTECTED HEALTH INFORMATION FROM:

 **Heart Specialists of Sarasota**

 **1950 Arlington St.**  Name of Health Care Provider

 **Suite 400**

 **Sarasota, FL 34239** Street Address

 **Phone: 941-917-4250**

 **Fax: 941-917-4257** City, State, Zip

 Phone or Fax:

**INFORMATION TO BE RELEASED:**

I hereby authorize you to obtain **all** of my medical records for any treatment and laboratory/diagnostic tests performed **except for**:

\_\_\_Sexually Transmitted Disease \_\_\_Alcohol Abuse Treatment \_\_\_ Mental Health Treatment

\_\_\_HIV (AIDS) \_\_\_Drug Abuse Treatment \_\_\_ Records from other facilities and

 providers

For the Following Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE FOR NEED OF DISCLOSURE: (check one)**

\_\_\_ Further Medical Care \_\_\_ Insurance/Eligibility

\_\_\_ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

I understand Imust be provided with a signed copy of this authorization. I understand written notification is necessary

to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office

of the above noted healthcare provider. I understand that Heart Specialists of Sarasota will not be able to release

my records to someone else without a signed authorization. If I decide not to sign this form, Heart Specialists of

Sarasota will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent

to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if

the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health

information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I

understand that I may be charged a fee for copying these medical records.

**SIGNATURE PATIENT/LEGAL REP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:** \_\_\_\_\_\_\_\_\_\_

 *(If signed by other than patient, state relationship and authority to do so.)*

**EXPIRATION DATE:** This authorization is good until the following date(s) or for twelve (12) months from the date signed. Distribution of copies: Original to provider; copy to patient; copy to accompany released records REV. 07/16