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**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