Orlando Heart & Vascular Center

11616 Lake Underhill Road, Suite 215 Orlando, Florida 32825
Office: (407) 482-7788 Fax: (407) 482-8698

Authorization for Request or Release of Medical Records

I, _____, hereby authorize Orlando Heart and Vascular Center, LLC to request/release the following protected health information request: ☐ **From** ☐ **To**

_____

_____

(Please include Doctors full name, address, telephone, and fax number if applicable)

Records Needed:

_____

☐ Office Visit ☐ Labs ☐ Stress ☐ ECHO ☐ EKG ☐ Cath ☐ Holter ☐ All Records ☐ Other

_____

Please fax all records to 407-482-8698

The authorization shall be in force and effect until for ☐ **ONE YEAR** ☐ **INDEFINITELY** 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 Orlando Heart and Vascular Center, LLC at 11616 Lake Underhill Road, Suite 215. I understand that a revocation not effective to the extent that OHVC 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 re-disclosure by the recipient and may no longer be protected by federal or state law. Orlando Heart and Vascular Center, LLC 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 the authorization.

_____ _____
Signature of Patient or Personal Representative Signature of Witness

_____ _____ _____
Patient Social Security Number Patient Date of Birth Date

_____ _____
Name of Patient or Personal Representative Relationship to Patient

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