

CARDIOVASCULAR SURGEONS, P.A.

CARDIAC ~ THORACIC ~ VASCULAR SURGERY

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____

to release to _____
(Name & Address)

Name of Patient _____ Date of Birth _____

To release information from my records including **PSYCHIATRIC, DRUG** and/or
ALCOHOL ABUSE OR HIV, and **AIDS** information.

Initial if you do not wish the above information released. _____

Office Use Only

____ Copy of Office Records	____ H & P / Discharge Summary
____ Operative Report	____ Lab/X-ray/Radiology
____ Other _____	
Office phone number _____	Fax number _____

____ **PLEASE FAX ASAP PATIENT IN THE OFFICE *** FAX # 407-422-0166*****

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION ON REDISCLOSURE: Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal Regulations (42CFR Part 2) prohibited recipients from making any further disclosure of this information except with the specific written consent of the patient. HIV testing, Arc, and/or Aids related diagnosis is further prohibited from disclosure by State Regulation without the specific written consent of the patient. A general authorization for the release of information if held by another party is **not** sufficient for this purpose.

*Signed _____ Date _____ Witness _____
(patient or legal guardian)