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# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date: _____ Date of Birth: _____ SSN: _____

Patient Name: _____

Address: _____

I, the undersigned, do hereby grant permission for Florida Cardiovascular Association to ☐obtain from or ☐release to:

_____
(Name of person or institution the information will be coming from)

_____
(Address of person or institution the information will be coming from)

The following information from the patient's clinical record:

_____

_____

_____

I understand that this information will be used for the purpose of:

- ☐ Providing information to allow care to be provided to the patient
- ☐ Providing information to the physician regarding the care provided
- ☐ Supporting the payment of an insurance claim
- ☐ Other: _____

This authorization will be valid for the period of twelve months unless otherwise specified below.

*I understand that I may revoke this consent at any time by sending a written notice to the above named pharmacy. I understand that any release which has been made prior to my revocation which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the above named physician.*

_____ _____
Signature of Patient or Patient's Authorized Representative Relationship of Authorized Representative

_____ _____
Date Pharmacy Representative/Date

**Specific authorization for release of information protected by state or federal law** - I specifically authorize, by writing my initials beside the category and signing below, the release of data and information relating to:

☐Substance abuse
☐Mental Health
☐AIDS/HIV

_____
Signature and date of Patient or Patient's Authorized Representative

**Prohibition on Redisclosure**

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse, by state law for mental health records or HIV/AIDS related records, federal requirements (42 CFR Part 2) and state requirements (Iowa Code chs.228/141) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS information.