AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize _____ ("Provider") to disclose protected health information ("PHI") regarding:
Patient Name: _____ Patient Date of Birth: _____
Patient Address: _____

I authorize the PHI to disclosed at my individual request to **HEART, VASCULAR & VEIN OF TAMP BAY** at the following locations:

☒ 625 W Lumsden	Brandon, FL 33511	All Day Monday, Tuesday, Thursday	**Phone: 813-755-3500** **Fax: 813-755-3300**
☐ 1901 Haverford Ave, 111	Sun City Center, FL 33573	All Day Friday	
☐ 10141 Big Bend Rd #201	Riverview, FL 33578	Wednesday After 1 PM	
Secure Email: Preferred Method | Hoshedar.Tamboli@HeartDr.DirectByGreenway.com			

Check one:
I authorize the following PHI to be released:

✓ All health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information;

____ For a limited time period beginning _____ and ending _____ all health information about the patient in the possession of Provider, including, but not limited to psychiatric, mental health treatment information excluding psychotherapy notes, HIV test results, genetic testing information or alcohol or drug treatment information;

____ Limited PHI about the patient in the possession of Provider to exclude the following information which I request not be disclosed: _____ _____.

____ Other, as described here _____.

I understand and acknowledge the following statements:

1. I may revoke this authorization at any time by notifying the Provider in writing of the revocation, unless the Provider has already relied on this authorization to disclose PHI;
2. PHI disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy laws;
3. I am signing this authorization voluntarily. I may decline to sign this authorization. However, refusal to sign does not stop the Provider's disclosure of PHI that is otherwise permitted to be disclosed by law without my specific authorization;
4. Provider will not condition my treatment on whether I sign, or refuse to sign, this authorization:
5. I will receive a signed copy of this form.
6. I understand that unless otherwise revoked, this authorization will expire one year after the patient is discharged from Provider's care.

Check one:

✓ I am the patient and I understand and agree to the provisions of this authorization.

____ I understand and agree to the provisions of this authorization on behalf of the patient named above, I have signed my name individually as the parent of a minor patient OR as the representative of the adult patient and have attached, or previously provided, a copy of the document authorizing me to serve as the patient's legal representative.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Parent/Legal Representative/Competent Adult (if applicable) Date

_____ _____
Signature of Witness Date

It is very important that this form be returned first so we may prepare for your visit with previous records. Please send the paperwork back to us by one of the following methods (in the order of preference):

1. Drop it at one of the locations listed above in person – Brandon Office Monday, Tuesday and Thursday, Riverview Office - Wednesday (after 1 PM) and Sun City Office – Friday
2. Scan and Email it to : Hoshedar.Tamboli@HeartDr.DirectByGreenway.com
3. Fax it to 813-755-3300
4. Mail it to us at 621 W Lumsden Road, Brandon, FL 33511