AUTHORIZATION TO DISCLOSE MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____City: _____ Zip Code: _____

I, _____, authorize the release of medical records/protected health information as specified in this authorization for the above named patient.

FROM:

☐ IVY Cardiovascular & Vein Center
Dr. Rishi Panchal
12983 Southern Blvd, Ste 205
Loxahatchee, FL 33470
Phone: 561-210-9495
Fax: 561-210-9475

☐ Physician/Facility:_____
Address: _____
_____
Phone: _____
Fax: _____

TO:

☐ IVY Cardiovascular & Vein Center
Dr. Rishi Panchal
12983 Southern Blvd, Ste 205
Loxahatchee, FL 33470
Phone: 561-210-9495
Fax: 561-210-9475

☐ Physician/Facility:_____
Address: _____
_____
Phone: _____
Fax: _____

INFORMATION TO BE DISCLOSED:

☐ Complete Medical Record
☐ Records of visit for specific date(s):
Date(s): _____
☐ Test Results Only
☐ Consultation Notes Only
☐ Operative/Procedure Reports
☐ Other: _____

PURPOSE OF DISCLOSURE:

☐ Continuity of Care
☐ Insurance
☐ Legal Purposes
☐ Personal Use
☐ Other: _____

ACKNOWLEDGEMENT OF UNDERSTANDING

- I understand my records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law.
- I understand once my information is disclosed to the recipient above, it may be redisclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA.
- I understand my records may contain information pertaining to treatment/diagnosis of mental health, drug and alcohol abuse, and communicable diseases including HIV/AIDS.
- I understand that signing this authorization is voluntary and will not affect my receipt of treatment.
- I understand I may revoke this authorization at any time, in writing, provided that the information has not yet been released.
- I understand this authorization will expire in 1 year or until I revoke it in writing.

Date: _____

Patient or Authorized Representative Signature: _____

Relationship to Patient:_____