3901 University Blvd., Suite 221
Jacksonville, FL 32216
Phone: (904) 423-0010 Fax: (904) 423-0012

100 Whetstone Place, Suites 102 & 310
St. Augustine, FL 32086
Phone: (904) 342-8300 Fax: (904) 342-8301
www.firstcoastheart.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name:_____Date of Birth:_____/_____/_____
Address:_____
City/State/Zip Code: _____
Patient's Phone: ( )_____

☐ I authorize First Coast Heart & Vascular Center to ***release*** my medical information to:

OR

☐ I authorize First Coast Heart & Vascular Center to ***obtain*** my health information from:

_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone# (include area code)	_____ Phone# (include area code)
_____ Fax# (include area code)	_____ Fax# (include area code)

PURPOSE FOR THIS REQUEST: (check one)

▫ Healthcare ▫Personal ▫Transfer or Continuation of Care ▫Other Explain: _____

TYPE OF RECORDS REQUESTED: (Check One)

▫All medical records related to a specific illness, procedure, hospitalization, etc.

_____
Specify illness, procedure, hospitalization, etc. Date(s) of treatment

▫Treatment Summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

▫Specific information (Select one or more as applicable):

▫ Procedure Report ▫ History & Physical ▫ Laboratory test results ▫Radiology reports ▫ Office Notes

▫Other: _____

▫Copy of entire medical record.

AUTHORIZATION VALID FOR: (Check One)

▫This request only.

▫One year from the date of this authorization **OR**_____. (Insert date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

▫This request **AND** for medical records of any **future** treatment of the type described above until_____(insert date)

I understand that:

- My right to healthcare treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address below except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by federal privacy regulations, the information stated above could be re-disclosed.
- Authorization for Release of HIV/AIDS related information, mental health, or substance abuse diagnosis and treatment information will expire in **60 days**.
- There may be a charge for the request records.

Signature of Patient/Legal Representative_____Date:_____

Printed Name of Signer:_____

Relationship to Patient:_____