Heart & Vascular, PLC

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REQUEST FOR RELEASE OF MEDICAL INFORMATION

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about our use of a patient's Protected Health Information (PHI).

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____
_____

Patient Request: ___ Copies of the following Health Care Information*

__ History and Physical __ Operative Report __ Cardiac Testing __ Office Visit Notes

__ Lab Reports __ Complete Medical Report

Purpose of Release: _____

The records will be sent to the following organization:

Organization Name: _____
Address: _____
_____

Telephone Number: _____
Fax Number: _____

* The cost of the records as governed by the FL Statutes is the following:
1 dollar each for pages 1- 25 and 25 cents per page for the remainder.

_____ _____
Signed (Patient) or (Representative, Relationship to patient) (Date)