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CARDIOVASCULAR SURGEONS, P.A.
CARDIAC ~ THORACIC ~ VASCULAR SURGERY

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize____

to release to____
(Name & Address)

Name of Patient________________________________Date of Birth_______________

To release information from my records, including **PSYCHIATRIC, DRUG** and/or **ALCOHOL ABUSE OR HIV,** and **AIDS** information.
Initial if you do not wish the above information released.________________

Office Use Only

_____Copy of Office Records _____H & P/Discharge Summary

_____Operative Report _____Lab/X-ray/Radiology

_____Other____

Office phone number__________________ Fax number____________________

____ ***PLEASE FAX ASAP. PATIENT IN THE OFFICE ****FAX # 407-422-0166*******

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION ON REDISCLOSURE: Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by federal law. Federal Regulations 42CFR Part 2) prohibited recipients from making any further disclosure of this information except with the specific written consent of the patient. HIV testing, Arc, and/or AIDS related diagnosis is further prohibited from disclosure by State Regulation without the specific written consent of the patient. A general authorization for the release of information if held by another party is ***not*** sufficient for this purpose.

*Signed__________________________________ Date__________ Witness________________________
(Patient or Legal Guardian)