

LORVEN HEART AND VASCULAR INSTITUTE, P.A.

Nagender A. Reddy, M.D.
1609 SW 17th Street
Ocala, FL 34471

Phone: (352) 401-9888 Fax: (352) 401-9852

AUTHORIZATION FOR RECEIPT AND/OR DISCLOSURE OF PROTECTED MEDICAL RECORDS INFORMATION

Patient Name: _____
Last First MI Maiden or other name
Date of Birth: _____ SS#: _____ / _____ / _____
MM/DD/YEAR
Address: _____ City: _____ Zip _____
Day Telephone: _____ Evening Telephone: _____

I hereby authorize the below named to release/receive information from my medical records as indicated below to/from Lorven Heart and Vascular Institute, P.A.

Name: _____
Address: _____ City: _____ Zip _____
Telephone: _____ Fax: _____

Purpose of Release (for example: continued care, personal, etc.) _____
Information to be released:

Dates: _____

History and physical Exam _____
 Progress Notes _____
 Lab Note _____
 X-Ray Reports _____
 Other _____

I specifically authorized the release of information relating to:
 Substance Abuse (including alcohol/drug abuse)
 Mental Health (including psychotherapy notes)
 HIV related information (AIDS related testing)

Signature of Patient or Guardian

Date

As required by State and Federal Law, Lorven Heart and Vascular Institute, P.A. may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your Signature on this form indicates you are giving permission for the uses and disclosures of the Protected Health Information described on this form.

I understand that State Law prohibits the re-disclosure of the information disclosed to the person(s) listed above without further authorization, but that Lorven Heart and Vascular Institute, P.A. cannot guarantee that the recipient of the information will not re-disclose this information contrary to such a prohibition.

I understand that this disclosure will remain in effect for one (1) year or until I revoke it in writing. I understand that if I revoke this authorization, I must do so in writing to **Lorven Heart and Vascular Institute, P.A.** Medical Records Department, 1609 SW 17th Street, Ocala, Florida 34471. I further understand that any such revocation does not refer to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will depend on whether or not I sign this authorization.

I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I hereby release **Lorven Heart and Vascular Institute, P.A.** and its employees from any and all liabilities that may arise from the release of information as I have directed.

I understand that I may be charged a fee of up to one dollar (\$1.00) per page, (plus applicable tax and handling) for every page copied. This fee is waived for copies provided to a health care provider for continuing medical care. I understand this falls within the limits allowable by Florida Law.

I HEREBY AUTHORIZE LORVEN HEART AND VASCULAR INSTITUTE, P.A. TO RELEASE/RECEIVE MY HEALTH CARE INFORMATION AS DESCRIBED ABOVE.

Signature of Patient

Date

Signature of Parent or Guardian

Date

Relationship to Patient