Daytona HEART Group

RECORDS RELEASE AUTHORIZATION

DAYTONA HEART GROUP
695 N Clyde Morris Blvd Daytona Beach FL 32114

Phone #: 386-258-8722
Fax #: 386-258-9443

Patient name: _____Date of birth: _____

I. My Authorization

This authorization is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmissible diseases.

Records we need:_____
You may disclose this health information to:
Name (or title) and organization _____
Address: _____
Phone #: _____Fax #:_____
You may disclose this health information FROM:
Name (or title) and organization _____
Address: _____
Phone #: _____Fax #:_____

Purpose of release (For example: continued care, personal, etc): _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
However, I do have to sign an authorization form:

- To take part in a research study. Or
- To receive health care when the purpose is to create health information for a third party.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office, or
- Write a letter to the office

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____

_____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.