Cardiac Surgical Associates

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

SECTION 1: Authorization

I request and authorize _____ to provide information or records regarding:

Name: _____
Last name First name Middle initial

Address: _____

Phone: _____ Date of Birth: _____ SS#: _____

Organization authorized to receive information or records:

❑ Cardiac Surgical Associates of Northside	❑ Cardiac Surgical Associates of Brandon	❑ Cardiac Surgical Associates of Osceola
6006 49th Street North, Suite 310	270 South Moon Avenue	720 West Oak Street, Suite 360
St. Petersburg, FL 33709	Brandon, FL 33511	Kissimmee, FL 34741
Phone (727) 527-9779 - Fax (727) 522-0415	Phone (813) 571-9988 – Fax (813) 571-9922	Phone (407) 846-0090 – Fax (407) 846-0072

Specific information to be used or disclosed (including dates if needed): _____

_____

Reason for disclosure/purpose of disclosure: _____

_____

This authorization will expire in 180 days or on: _____
Date or event

SECTION 2: Important Information About Your Rights

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time prior to the expiration date or event noted above in writing. The cancellation will not affect any information either received or given before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment.

SECTION 3: Signature

_____ _____
Patient Signature *Date*
Form must be completed before signing.