



# 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:

<input type="checkbox"/> Cardiac Surgical Associates of Northside 6006 49 <sup>th</sup> Street North, Suite 310 St. Petersburg, FL 33709 Phone (727) 527-9779 Fax (727) 522-0415	<input type="checkbox"/> Cardiac Surgical Associates of Brandon 270 South Moon Avenue Brandon, FL 33511 Phone (813) 571-9988 Fax (813) 571-9922	<input type="checkbox"/> Cardiac Surgical Associates of Largo 1345 West Bay Drive Largo, FL 33770 Phone (727) 587-7100 Fax (727) 585-3290	<input type="checkbox"/> Cardiac Surgical Associates of Fawcett 2525 Harbor Blvd, Suite 205 Port Charlotte, FL 33952 Phone (941) 255-7020 Fax (844) 829-8541
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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  
Form must be completed before signing.

\_\_\_\_\_  
Date