FLORIDA CARDIAC CONSULTANTS, INC.

Medical Information Release Form

(HIPPA Release Form)

Name:_____ DOB: _____/_____/_____

I authorize the release of medical information including my diagnosis, records, examinations, test results and claims information.

This information may be released to: (Please include name AND phone number)

- ☐ Spouse:_____Phone:_____
- ☐ Child(ren):_____Phone:_____
- ☐ Other:_____Phone:_____

Please check box if information is not to be released to anyone ☐

Messages

Please call:
- ☐ Home:_____
- ☐ Work:_____
- ☐ Mobile:_____

If unable to reach me:
- ☐ You may leave a detailed message
- ☐ Leave message for a return call (no details)
- ☐ Other: _____

Signed:_____ Date: _____/_____/_____

This Release of Information will remain in effect until terminated in writing.