MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

For Clinic Use Only:
Method of Retrieval (Check One):
□ Picked Up □ Mailed □ Faxed
Date Received: _____
Date Processed: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Telephone: _____ Gender: ☐ Male ☐ Female

Social Security No.: _____ Email Address: _____

RELEASE INFORMATION FROM:

☐ Manatee Cardiovascular Wellness Institute
☐ Other (Specify facility/individual & address below, including phone/fax number is known)
_____
_____
_____
Ph: _____ Fax: _____

RELEASE INFORMATION TO:

☐ Manatee Cardiovascular Wellness Institute
☐ Other (Specify facility/individual & address below, including phone/fax number is known)
_____
_____
_____
Ph: _____ Fax: _____

Purpose of release/disclosure to other person/organization:
☐ Continuation of Care/Transfer of Care ☐ Attorney/Legal □ Insurance Company
☐ Workman's Compensation ☐ Other (specify):_____
_____

Information to be Released: Services Dates (Optional) From: _____ To: _____
☐ History & Physical ☐ Office Visits ☐ Lab Reports ☐ X-Ray Reports
☐ Diagnostic Reports ☐ Billing Information ☐ Other: _____

I understand that this authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization shall remain valid until written notice is given by me revoking said authorization.

_____ _____/____/_____
Signature of Patient or Legally Authorized Representative **DATE** (mm/dd/yyyy)

_____
Printed Name of Legally Authorized Representative
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Next-of-Kin □ Legal Guardian

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ADDITIONAL INFORMATION REGARDING YOUR REQUEST

Requesting medical records on behalf of another person
If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavit of Heir at law, etc. Please contact our office to determine the documentation that will be required to process your request.

Submitting requests & receiving record copies – Requests for medical records may be:

- Mailed to Manatee Cardiovascular Wellness Institute, Attn: Medical Records, 2816 Manatee Avenue West, Bradenton, FL 34205.
- Faxed to Manatee Cardiovascular Wellness Institute, Attn: Medical Records at (941) 744-1500
- Submitted in person Monday – Friday 8:00 AM – 5:00 PM to the located noted above.

Our average turnaround time for processing requests is seven business days plus shipping time. Unless otherwise requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please include your phone number on your request, in case we need to contact you for additional information. **For questions regarding requests for medical record copies, please call: (941) 744-1200.**

Fees are authorized annually by the State of Florida Rule 64B8-10.003, Florida Administrative Code. Some records requested for legal, insurance, or personal use may require a prepayment. If your request requires pre-payment, a fee notice will be sent to you upon processing of your request. Records fees will be billed as follows (plus actual postage):

Patient (paper copy):

- Pages 1-25 $1.00
- Pages 25+ $0.25 for each additional page