MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Facility Requests Information to be Sent From MCWI

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

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

Social Security No.: _____ Email Address: _____

Street Address: _____

City/State/Zip: _____

_____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Company/Organization: _____

Street Address: _____

City/State/Zip: _____

Facility Telephone: _____ Facility Fax: _____

Select delivery method: ☐ US Mail ☐ Pick-Up ☐ Faxed

Dates and Type of Information to Disclose:

□ 2 years prior from last date seen

□ Dates Other: _____

□ Specific Information Requested:

_____

_____

_____

Purpose of Disclosure:

□ Change of Insurance or Physician
□ Continuation of Care (e.g., VA Med Ctr)
□ Referral
□ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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ACKNOWLEDGEMENT OF UNDERSTANDING:

1. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
2. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
3. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.

_____ _____/____/_____
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

ADDITIONAL INFORMATION REGARDING 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.