Orlando Primary Medicine
11616 Lake Underhill Rd, Suite 205 Orlando, FL 32825
Phone: (407) 601-5308 Fax: (407) 482-8698

Authorization for Release of Information

Name: _____ DOB: ___/___/____ SS#: _____/_____/_____

Give authorization for Orlando Heart and Vascular Center, LLC to (CHECK ONE ONLY):

__ Obtain my records from: _____

__ Release my records to: _____

Records Needed:

□ Office Visit □ Labs □ Stress □ Echo □ EKG □ Cath □ Holter □ All Records

Name of person or facility receiving: _____

Address: _____

Phone: _____ Fax: _____

I authorize Orlando Heart and Vascular Center to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Orlando Heart and Vascular Center to release all medical information to my referring physician and my primary (family) physician. I authorize Orlando Heart and Vascular Center to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Orlando Heart and Vascular Center.

I agree that these provisions will remain in effect until I provide written revocation to Orlando Heart and Vascular Center.

Signature of Patient/Legal Guardian: _____Date: _____