SeaCoast
CARDIOLOGY CONSULTANTS, PLLC

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HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Disclaimer: This document is provided solely for reference purposes.

I, _____, give authorization for SeaCoast Cardiology Consultants, PLLC to release or discuss medical records for any treatment or exam rendered to me at any time to the individual(s) listed below. I authorize this Health Provider and/or staff to leave medical or account information pertaining to my care by the following methods: **written** (obtaining a copy of my medical information via fax, mail, personally pick-up from your office) or **verbal** (via telephone, voicemail, personally speaking to clinical staff in your office) with the listed individual(s) and will assume responsibility for notifying them whenever this information changes:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization expires one (1) year after the date that this authorization is signed & dated. Finally, you may revoke or change the individuals on this authorization in writing only. Your notice will not apply to actions taken by the requesting person(s) prior to the date they receive your written request to revoke authorization.

_____ _____
Printed Name Signature

_____
Date

_____ _____
Witness Date

Please Flip Over To Continue