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ORLANDO CARDIAC & VASCULAR SPECIALISTS LLC

Rajesh Shah, M. D. FACC
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OCVS Authorization of Medical Records Form

I _____ hereby authorize **Orlando Cardiac & Vascular Specialists LLC** to
(Print Patient Name)
obtain/release my Protected Health information from/to the following person(s) and/or organization(s):

Doctor/Health Provider or Plan Name:	Phone Number: ( ) -	Fax Number: ( ) -	**Purpose of Records Request:** ☐ Release to OCVS ☐ Obtain from OCVS
Doctor/Health Provider or Plan Name:	Phone Number: ( ) -	Fax Number: ( ) -	**Purpose of Records Request:** ☐ Release to OCVS ☐ Obtain from OCVS
Doctor/Health Provider or Plan Name:	Phone Number: ( ) -	Fax Number: ( ) -	**Purpose of Records Request:** ☐ Release to OCVS ☐ Obtain from OCVS
Doctor/Health Provider or Plan Name:	Phone Number: ( ) -	Fax Number: ( ) -	**Purpose of Records Request:** ☐ Release to OCVS ☐ Obtain from OCVS

I authorize the following information to be obtained/release: ☐ All Records ☐ Other: _____

_____

The information disclosed may include matters regarding mental health, developmental disability, alcohol and drug abuse, child abuse and neglect, sexual assault, adult disabilities, and infectious disease including HIV. Refusal of information will result in such confidential records not being released. If you do not wish for such information to be released, state information to be excluded: _____.

This authorization is valid for records from _____ to _____/ ☐ current care.
(Specify dates, if less than one year)

_____*I understand that I have a right to revoke this authorization at any time.* My revocation must be in writing in a letter provided to the Office Manager of **Orlando Cardiac & Vascular Specialist LLC (OCVS)**. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that **OCVS** may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

_____*I agree that a copy of this release or fax of this release shall be as valid as the original release.* If I authorize **OCVS** to fax information, I realize there are inherent risks in faxing Protected Health information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider.

I understand that I will get a copy of this form after I sign upon request.

_____ _____ _____
Printed Name of Patient or Patient Representative | Patient Date of Birth | Patient Last Four of SSN

☐ Self

_____ _____ _____
Signature of Patient or Patient Representative | Todays Date | Relationship to Patient