RECORDS REQUEST

I, the undersigned patient or legal representative, hereby authorizes Pham Cardiovascular Center to request any health information, including the diagnosis and records of any treatment or examination rendered to me.

Patient Name: ____ Date of Birth ________________

____

To: ____________________________________ Fax: ______________________________________

This information may be disclosed to and used by the following:

Pham Cardiovascular Center

4141 Southpoint Drive East

Jacksonville, FL 32216

Phone: (904) 513-3179 Fax: (904) 337-1641

The dates of service and the type(s) of information to be used or disclosed are as follows:

DATE(S) OF SERVICE: ____

RECORDS REQUESTED:____

This request is for the purpose of treatment, payment, and/or Health Care operations.

____

This authorization will be valid while I am a current patient with Pham Cardiovascular Center. I understand that I may revoke this authorization at any time by notifying Pham Cardiovascular Center in writing, but if I do it will not have any effect on actions that Pham Cardiovascular Center took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that I may inspect or copy the information to be used or disclosed.

Signature of Patient or Legal Representative: ____
Print Name: ____ Date: ________________

If signed by a Legal Representative, indicate your relationship to the patient below and provide appropriate documentation to verify your authority:

□ Parent □ Guardian □ Conservator □ Executor of Estate □ Power of Attorney □ Other