PENSACOLA CARDIOLOGY

W. Daniel Doty, MD, FACC, FAHA

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Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name _____ **Date of Birth** ___/___/___ **Social Security #**_____-_____-_____

By signing this authorization, I authorize W. Daniel Doty, MD, Pensacola Cardiology, P.A., Pensacola, Florida, to obtain certain protected health information about me from (check or list the applicable location, then fax or mail a separate form to each location):

☐ Cardiology Consultants Medical Records, 275 West Airport Boulevard, Pensacola, FL 32505 Fax 850-857-1747 Phone 850-484-6633
☐ Baptist Hospital Medical Records, 100 Garden Street, Suite 400, Pensacola, FL 32502 Fax 850-469-2124 Phone 850-434-4901
☐ Gulf Breeze Hospital, Attn Medical Records,1110 Gulf Breeze Pkwy, Gulf Breeze, FL 32561 Fax 850-934-2149 Phone 850-934-2000
☐ Sacred Heart Hospital Medical Records, 5151 North 9th Avenue, Pensacola, FL 32504 Fax 850-416-7727 Phone 850-416-7606
☐ Sacred Heart Cardiology Medical Records, 5252 N. 9th Avenue, Pensacola, FL 32504 Fax 850-416 4969 Phone 850-416-4970
☐ D.W. McMillan Hospital Medical Records, 1301 Belleville Avenue, Brewton, AL 35426 Fax 251-809-8197 Phone 251-809-8330
☐ South Baldwin Hospital Medical Records, 1613 N. McKenzie Street, Foley, AL 36536 Fax 251-949-3919 Phone 251-949-3400
☐ Northwest Florida Heart Group, 8333 N. Davis Highway, Pensacola, FL 32514 Fax 850-477-6137 Phone 850-969-7979
☐ West Florida Regional Medical Center, Parallon Business, Attn Med. Records, 335 Crossing Blvd, Plaza 2, Orange Park, FL 32073 Fax 855-668-0697 Phone 888-616-5721

☐ Other (primary care physician, etc.) _____

This authorization permits/requests the following individually identifiable health information about me to be obtained/released/faxed for the specified period from January 1, 2000, through the present date.

Please **FAX** the following information to Pensacola Cardiology, PA, **850-912-6869**:

(1) All office and hospital results/services provided to me by my physician or other practitioner(s) within the entitie(s) named for the past two years and also
(2) the most recent office and hospital information and results, if provided prior to the past two years, to include all:

Office visits, history and physical exams, consultations, discharge summaries, laboratory results, ECGs, electrophysiology procedures, echocardiograms, stress tests, Holter monitors, Event monitors, vascular ultrasounds (arterial and venous), cardiac catheterizations, cerebral and peripheral angiograms, coronary and valvular interventions/angioplasty/stents, cardiac and vascular surgical procedures, and my living will (advance care plan).

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to the facility medical records department. I understand that the revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on August 1, 2018.

I understand that authorizing the disclosure of these health records is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the information and the information may not be protected by the Federal or State Privacy Laws. I also understand that obtaining medical information under false pretenses is a Federal and State crime. If I have questions about disclosure of my protected health information, I can contact Pensacola Cardiology, P.A., Dr. William Daniel Doty at 850-912-6100.

_____ _____ _____

Signature of Patient or Legal Representative | Print Name of Patient or Legal Representative | Date

_____ _____

If signed by Legal Representative, Relationship | Signature of Witness to this form