



Patient Name: _____ Date of Birth: _____

By signing this authorization, I authorize W. Daniel Doty, MD, Patrick R Pagan, ARNP-C, & Pensacola Cardiology, PA, to obtain certain protected health information about me from: (Please complete, then Fax or Mail a separate form to Each listed location or Provider.)

Primary Care Provider: _____ Phone: _____

Former **Cardiologist(s)**: _____ Phone: _____

ALL Emergency Room Visits or Hospital Stays (In last 5 years): _____

Other Providers that would have records that would assist our Cardiologists in caring for you: _____

(Additional Providers can be written on back of this form – Check here if more Emergency Room Visits, Hospitals, & Providers listed on Back: _____)

This authorization permits/requests the following individually identifiable health information about me to be obtained/released/faxed for the specified period from January 1, 2018 through the present date.

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

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

Office visits, history & physical exams, consultations, discharge summaries, lab results, ECGs, electrophysiology procedures, echocardiograms, stress tests, Holter or Event monitor results, vascular ultrasounds (arterial & venous), cardiac catheterization, cerebral & peripheral angiograms, coronary & valvular interventions/angioplasty/stents, cardiac & vascular surgical procedures, & 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 so in writing to the facility the 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 law provides my insurer with the right to contest a claim under my policy.

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 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 medical information under false pretenses is a Federal and State crime. If I have any questions about disclosure of my protected health information, I can contact Pensacola Cardiology, PA., or Dr. W. 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.