AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____/_____/_____ SS#:_____

Address:_____ Telephone #:_____

Name of Healthcare Facility from which Records are Requested:

_____ Ph: _____ Fax: _____
(Please Print)
Address:_____ City:_____ State:_____ Zip:_____

Reason for Disclosure: ( ) Continued Medical Care ( ) Insurance Purposes

MAIL or FAX INFORMATION TO: **RAJESH DHAIRYAWAN, MD PA**
9900 SW 107th Ave. Suite 100 Miami, FL 33176
FAX: 305-412-2790 * PHONE: 305-412-0998

EMAIL: **office@miamiheartcare.org**
(May not be a secured method of communication)

I hereby authorize **RAJESH DHAIRYAWAN, MD PA** to obtain the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, genetic testing information, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

Check a Box ☑

	Complete Record:		Cardiac Catheterization Report:
	Laboratory Reports:		Echo / Nuclear Report:
	Hospital Admission / Discharge Note:		Coronary Bypass Surgery Report:
	Office Consultation / Progress Report:		Other (Specify):

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:
☐ Drug/ Alcohol Abuse or Treatment ☐ HIV/ AIDS or Sexually Transmitted Disease (STD) Test Results or diagnoses
☐ Genetic Testing Information ☐ Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken thereon**. This authorization and consent will expire (insert date) _____. (If left blank, the authorization form will be kept on file for future medical record requests).**
Your health care will not be affected by whether you sign or not this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ Date Signed: _____/_____/_____
Signature of Patient or Legal Representative

Printed Name, if not patient: _____ Relationship if not Patient: _____

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

**For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.