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 FAX OR EMAIL INFORMATION TO: **RAJESH DHAIRYAWAN, MD PA**
9900 SW 107th Ave. Suite 100 Miami, FL 33176
FAX: 305-412-2790 * PHONE: 305-412-0998
office@miamiheartcare.org

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This authorization is valid until the earlier of the occurrence of the death of the individual, or permission is withdrawn, or the following specific date (optional) _______/_______/_______.

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 you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request of this information (for example: power of attorney, healthcare surrogate form, order appointment of a guardianship, order appointing personal representative, letters of administration). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization.