



**Preventive Cardiology & Internal Medicine Associates, P.L.**  
**3606 Maclay Blvd. Suite 104**  
**Tallahassee, FL. 32312**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**PATIENT INFORMATION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Maiden: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ SSN \_\_\_\_\_ Phone: \_\_\_\_\_

**PHYSICIAN TO DISCLOSE (RELEASE)  
INFORMATION (PREVIOUS PRIMARY CARE MD OR  
ANY OTHER TREATING PHYSICIANS)**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

**PERSON OR ENTITY TO USE (RECEIVE) INFO:**

**Preventive Cardiology & Internal Medicine Associates**  
**3606 Maclay Blvd, Suite 104**  
**Tallahassee, FL 32312**  
**Phone: 850-210-0593**  
**Fax: 850-210-0315**

Specific Information to Be Disclosed: \_\_\_\_\_  
Dates of Service: \_\_\_\_\_  
For the Purpose of: \_\_\_\_\_  
This Authorization Will Expire On: \_\_\_\_\_

I understand that the information in my health record may include information relating to:

- Sexually Transmitted Diseases
- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV)
- Behavioral, Mental Health or Psychiatric Conditions
- Drug or alcohol abuse, drug-related and/or alcohol-related treatment

**I AGREE TO SUCH RELEASE: PLEASE INITIAL AND DATE:** \_\_\_\_\_

When my health information is used or disclosed pursuant to this authorization it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use or disclosure of any information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the PCAIMA Office, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information.

**Patient Signature or Patient's Representative:** \_\_\_\_\_ **Witness:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Date:** \_\_\_\_\_