Delaware Heart & Vascular, P.A.

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Milford Medical Annex
112 Sussex Avenue, Suite 101
Milford, DE 19963
(302) 393-5500 Phone
(302) 422-6129 Fax

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200 Banning Street, Suite 340
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315 North Carter Road
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO DELAWARE HEART & VASCULAR, P.A.

Patient Name: ____Date of Birth: _____/_____/_____/
Address: ____City: ___________________State: ___________ Zip: _________
E-Mail Address: _____________________________Phone: ______________________Social Security #: **XXX – XX** - _________

I request that my protected health information (PHI) from
Name of Physician or Facility: ____
Address: ____ City: ___________________ State: __________ Zip: ________
Phone: __________________ Fax (healthcare provider only): _____________________ E-Mail Address: ______________________________________

be disclosed to Delaware Heart & Vascular, P.A. ☐ **Dr. Abbrescia** ☐ **Dr. Rippert** ☐ **Dr. Patel**

☐ 200 Banning Street, Suite 340
Dover, DE 19904
302-734-2121 FAX

☐ 112 Sussex Avenue, Suite 101
Milford, DE 19963
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I authorize the following PHI to be released from my medical record(s):

☐ Discharge Summary
☐ History and Physical
☐ Operative Report
☐ Progress Notes
☐ Test Results: Date: ____________Type: ___________
☐ Radiology Report Date: _________
☐ Emergency Room Record Date: ___________
☐ Consultation Reports Date: __________
☐ EKG Report Date _________
☐ Laboratory Report Date: ________

Comments: ____

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No Dates: ____
HIV Testing and Results ☐ Yes ☐ No Dates:
Mental Health or Psychotherapy Records ☐ Yes ☐ No Dates:

Covering the period of health care from: ☐ ***Specific Date(s):*** ______________________________ ***to*** ______________________________ ***OR***
☐ ***All past, present and future encounters/visits.***

Disclosure Format (Paper is default if not marked):

☐ US Mail – paper format, ☐ FAX (healthcare provider only), ☐ E-Mail – secure format **OR** ☐ CD – secure electronic format

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: (ADDRESS). Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will ***expire on the following date/event/condition***: ________________________________
  If I fail to specify an expiration date/event/condition, this authorization will ***expire one year from the date signed***.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

____ ____/____/____ ____ ____/____/____/
(Signature of Patient) (Date) (Signature of Witness) (Date)

If you are signing as a Personal Representative for the above patient*, you will be asked to provide proof of your identity and of your authority to sign for the patient. Please fill out and sign below:*

Your name (please print): ____Your relationship to the patient: _______________________________
Your signature: ____ Date: _____/_____/_____

FOR OFFICE USE ONLY:

Information released by: ____Date: _____/_____/_____