Delaware Heart & Vascular, P.A.

Vincent D. Abbrescia, D.O., F.A.C.C. ▪ Judith A. Rippert, D.O., F.A.C.C. ▪ Sanjeev B. Patel, M.D., M.R.C.P., F.A.C.C.

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

Eden Hill Medical Center
200 Banning Street, Suite 340
Dover, DE 19904
(302) 734-1414 Phone
(302) 734-2121 Fax

Smyrna-Clayton Medical Service Center
315 North Carter Road
Smyrna, DE 19977
(302) 734-1414 Phone
(302) 734-2121 Fax

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FROM 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 *Delaware Heart & Vascular, P.A.* be disclosed to:
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-Mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

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: _____

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.***

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

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: ____/____/____