Dr. Peter Dovgan M.D., FACS
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Authorization to Disclose Health Information

1395 N. Courtenay Pkwy Suite 203
Merritt Island, FL 32953

Patient Name: ____
DOB:________________________________SSN:____________________________________
Address:____
City:______________________________________ FL. Zip:___________________________

☐ **I authorize and request Space Coast Vascular to RELEASE Medical Records to:**

Person or Organization:____
Phone:_____________________________________Fax:_____________________________

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability

☐ Transfer/ Reason________________________________☐ Other____________________

☐ **I authorize and request Space Coast Vascular to OBTAIN Medical Records from:**

Organization:____
Phone:_____________________________________Fax:_____________________________

Please: ☐ Fax ☐ Mail the following information from my medical record for care and/or treatment:

☐ Office and Progress Notes ☐ Procedure/ Surgery Reports ☐ Imaging Studies

☐ Diagnostic Studies ☐ Lab/bloodwork ☐ Other:_______________________

From the time period of ______________________ thru_____________________ / present.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by MAB and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.
- I understand that the health record may include information relating to sexually transmitted disease, acquired Immuno-deficiency syndrome (AIDS) or human immune-deficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that this authorization will remain in effect for 90 DAYS or until I revoke it in writing to the Health Information Management Dept.
- I understand that I may inspect or copy the information that is used or disclosed.

Patient Signature:_______________________________________Date:_________________
(Required for all patients 18 yrs and older. 18 yrs and older for psychiatric records, 14 yrs and older for substance use records)

Signature of Parent or Legal Guardian:_______________________ Date:_________________
(Required for all patients under age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)