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I hereby authorize you to release to: CARDIOLOGY PHYSICIANS, P.A. any information including the diagnosis and records of any treatment or examination rendered to me. This authorization will expire one year from the date of my signature below. I understand I can revoke this authorization at any time by writing to Cardiology Physicians, P.A. ; but that reckoning this authorization will not affect disclosures made or actions taken before the revocation is received. I understand that any personal health information or other information released to Cardiology Physicians, P.A. may be subject to redisclosure by Cardiology Physicians, P.A. and may no longer be protected by applicable federal and state privacy laws.

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