

**AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**

*The form below will authorize the release of patient information FROM Heart Endovascular and Rhythm of Texas (HEART) to another Provider*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Telephone Number(s): w=work, h=home, c=cell \_\_\_\_\_

How would you like to receive your records?(circle one)

Mail \_\_\_\_\_ Email (provide email address) \_\_\_\_\_

**The following information is to be released FROM Heart Endovascular and Rhythm of Texas (HEART):**  
Please circle all that apply:

Entire Record	Immunization Records	Laboratory Reports	Radiology/Imaging Reports
Consultation	Progress Notes	Most Recent History and Physical	Other:

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

**This above information is to be disclosed to:**

Provider (Doctor Name): \_\_\_\_\_ Fax #: \_\_\_\_\_

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

**Description or the purpose of the use and/or disclosure (please circle all that apply):**

Continuing Care	Second Opinion	Social Security/Disability	Personal Use
Consultation/Referral	Insurance	Legal Purposes	Other (please describe):

I understand that this authorization is voluntary, and I may refuse to sign this authorization, I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand Heart Endovascular and Rhythm of Texas has fees for the type of records provided. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. **This authorization will be in effect until \_\_\_\_\_ (date of event).**

I understand I may revoke this authorization at any time by notifying Heart Endovascular and Rhythm of Texas. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Patient Signature: x \_\_\_\_\_ Printed Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Legal Authority(attach supporting documents): \_\_\_\_\_

