www.heartdoc.care
Office: (512) 504-7411
Fax: (512) 215-8824
info@heartdoc.care

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

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

Patient Name: _____ **Date of Birth:** _____

Address/City/State/Zip: _____

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

Request Records from a provider (Be sure to complete this section to prevent delays in obtaining your records):

Name of Doctor/Provider/Organization: _____

Phone #: _____ **Fax #:** _____

Address/City/State/Zip: _____

The following information is to be released TO Heart Endovascular and Rhythm of Texas (HEART) at fax # 512.215.8824 or via email at info@heartdoc.care
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.

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:_____

Dripping Springs Medical Building:
170 Benney Lane
Suite 100
Dripping Springs, TX 78620

South Austin:
4310 James Casey St.
Bldg 1, Suite A
Austin, TX 78745

Lakeway:
101 Medical Parkway
Suite 220
Austin, TX 78730

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