CARDIOLOGY AND TRANSPLANT ASSOCIATES
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

Previous or Other Name(s) _____
(please enter if the medical records may be under a different name, e.g. maiden name, alias, etc.)

Address :_____

_____

Social Security Number (Optional):_____

I hereby authorize Cardiology and Transplant Associates to release the following records:

□ Cardiology Reports (Echocardiography, Stress test, Holter, Cardiac Catheterization, EP Study, etc)
□ Laboratory Reports
□ Radiology Reports
□ Other *(please specify)* _____

□ History and Physical and progress notes
□ Operative Reports
□ Discharge Summary

For the following dates: _____

Purpose of disclosure:

_____

Please release requested records to:

□ Myself OR □ To the following entity: _____

_____

Fax: _____

By signing this Authorization Form, I understand and agree to the following (1) I am giving my authorization for Cardiology and Transplant Associates to release specified protected health information relating to my diagnosis, testing or treatment; (2) my expressed consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, and I specifically authorize Cardiology and Transplant Associates to release all such information; (3) the information disclosed pursuant to this authorization may be re-disclosed by the recipient, and any such re-disclosure may no longer be protected under US federal and/or Texas privacy laws, (4) I specifically agree to hold Cardiology and Transplant Associates, its officers, employees and agents harmless from all damages, whether direct or consequential from such redisclosure; (5) this authorization is voluntary and I may decline to sign this Authorization Form; (6) I am not required to sign this Authorization Form in exchange for any treatment from Cardiology and Transplant Associates; (7) I may revoke this authorization at any time by notifying Cardiology and Transplant Associates of my intent to do so in writing at the address above, however, such revocation will not have any effect on any information already disclosed by Cardiology and Transplant Associates before it received my written notice of revocation; (8) if I do not revoke this authorization, it will expire on the 181st day after the date indicated below, and (9) fees may apply for copying and delivering the above information to the intended recipient and such fees are regulated by Texas Medical Board.

_____ _____
Signature of Patient or Authorized Personal Representative **Date**

_____ _____
Printed Name **Relationship to the Patient**