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 release of medical records from:

Name _____

Address _____

_____

Phone: _____ Fax: _____

I authorize Cardiology and Transplant Associates to obtain the protected health information as follows:

- ☐ Cardiology Reports (Echocardiograms, Stress Tests, Holter or Event Monitors, Cardiac Catheterization Reports, EP Studies, etc)
- ☐ History and Physical
- ☐ Laboratory Reports (last 6 months)
- ☐ Operative Reports
- ☐ Radiology Reports (last 6 months)
- ☐ Discharge Summary
- ☐ Office notes (last 6 months)
- ☐ Other _____

Please send requested medical records to:	**Cardiology and Transplant Associates** **12234 Shadow Creek Pkwy, Suite 6106** **Pearland, TX 77584** **Phone: (713) 436-6653** **Fax: (713) 436-6365**

By signing this Authorization Form, I understand and agree to the following: (1) the specific purpose of the information obtained is continued medical care at Cardiology and Transplant Associates; (2) I am giving my authorization for Cardiology and Transplant Associates to receive all protected health information relating to my diagnosis, testing or treatment; (3) 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 the recipient of this Authorization Form to release all such information to Cardiology and Transplant Associates; (4) the information disclosed pursuant to this authorization may be re-disclosed by Cardiology and Transplant Associates, and any re-disclosure to other recipients may no longer be protected under US federal and/or Texas privacy laws; (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 used or disclosed to or 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.

_____ _____

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

_____ _____

Printed Name **Relationship to the Patient**