TEXAS HEART & VASCULAR

MEDICAL RECORDS RELEASE

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ______________

Social Security #: ______________ Address: ______________________

Phone: ______________ Cardiologist: ______________________

RECORD TO BE RELEASED FROM

Physician Name/Clinic: ______________________ Phone: ______________

Address: ______________________ Fax: ______________

RECORD TO BE RELEASE TO

Name: **Texas Heart & Vascular** Phone: **512-623-5300**

Address: **4316 James Casey St. Bldg A & C Austin TX 78745** Fax: **512-904-1702**

RELEASE THE FOLLOWING

- ☐ Cath/Op Reports
- ☐ Echo Reports
- ☐ EKG
- ☐ Entire Chart
- ☐ Lab Reports
- ☐ Progress Note
- ☐ Treadmill Results
- ☐ X-rays
- ☐ Other:

PURPOSE OF DISCLOSURE

- ☐ Attending Physician Statement
- ☐ Consultation
- ☐ Disability
- ☐ Further Medical Care
- ☐ Legal Investigation
- ☐ Payment of Claim
- ☐ Personal
- ☐ Research Participation
- ☐ Other:

I hereby authorize the release of my medical records, including all results and tests that may include the following data: drug, alcohol, and psychiatric treatment to the party noted above.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
I understand that I do not have to sign this authorization and my treatment or payments for services will not be denied if I do not sign this form unless specified above under Purpose of Disclosure.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will expire ninety (365) days from the date of my signature or as otherwise specified by date, event, or conditions as follows:

Patient Signature: ______________________ Date: ______________

Witness: ______________________ Date: ______________