AUTHORIZATION TO RELEASE PATIENT INFORMATION

Fax form back to 817-252-5049

1. **Patient's Full Name**: ____

2. **Patient's Date of Birth**: ____________________ **Patient's Social Security No:** ____________________

3. **I authorize __Consultants in Cardiology_____ to □ release □ obtain protected health information.**

4. I request that the following protected health information be released:

Check the box(es) which best describes the information to be released and disclosed.

□ Physician Office/Progress Notes □ Laboratory Reports □ Radiology/X-Ray Reports □ Stress Test Report
□ Medication/Prescription Records □ EKG Reports □ Echo Reports □ Billing Records

□ Other: ____

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5. I understand the information to be released or disclosed may include information relating to treatment or testing for sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric treatment, behavioral or mental health services, and alcohol and drug abuse. I authorize the release or disclosure of the type of information described in this section.

6. I request the protected health information be □ released to □ obtained from:

Name (Individual or Organization):____

Address: ____

____

Telephone Number: ____________________ FAX Number: ____________________

7. The purpose or reason this information is needed: (check all which apply)
□ Legal Purpose □ Insurance □ Personal Use □ Medical Care □ Military □ School
□ Social Security Disability □ Workers Compensation □ VA Medical Center
(Social Security, Workers Comp and VA Medical Center requests require documentation of a pending claim.)

□ Other: ____

8. **I understand the following:**
    1. I have a right to revoke this authorization in writing at anytime except to the extent action has been taken in reliance upon this authorization.
    2. The information released in response to this authorization may be re-disclosed to other parties and can no longer be protected by this health care provider.
    3. My treatment or payment for my treatment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.
    4. I may be charged a fee for copies of these medical records according to State and Federal Laws.

9. **This authorization will expire One Hundred Eighty (180) days from the date signed below.**

____ ____________________
Signature of Patient or Legally Authorized Representative Date Signed
(Fill out this authorization completely or your request may be delayed)

____ ____________________
Relationship of Legally Authorized Representative to Patient Telephone Number

Questions - Call 817-252-5000 PF-2300