



AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient's PRINTED Name: _____ Date of Birth: _____

Complete Address: _____

Home Phone Number: _____ Cell Phone Number: _____

I hereby authorize Pearland Cardiovascular Associates to disclose records obtained in the course of my evaluation and/or treatment to: (name/address of person or organization to which disclosure is to be made)

Name: _____

Complete Address: _____

Attention: _____

I would like for these records to be sent by: _____ mail _____ fax _____ picked up
(Please do not ask for these to be faxed to your personal fax. We will only fax records to physician offices for continued care) I hereby release Pearland Cardiovascular Associates from any/all legal liability that may arise from the release of this information to the party mentioned above.

I am requesting copies of the following:

- | | | |
|------------------------------|---------------------------|--------------------|
| _____ ALL HEALTH INFORMATION | _____ BILLING INFORMATION | _____ LAB RESULTS |
| _____ PATIENT ALLERGIES | _____ OPERATION REPORTS | _____ OFFICE NOTES |
| _____ CARDIOLOGY REPORTS | _____ EKG | |

Other (please specify) _____

These are being released for the purpose of _____
(example: personal (*fee included), continued care, etc.)

I ___ do (or) ___ do not consent to release information relating to psychiatric or psychological testing or treatment, sexually transmitted diseases, alcohol/drug abuse and/or HIV (AIDS virus) testing/results. If I have been tested, diagnosed for treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are hereby specifically authorized to release all information to the above relating to such diagnosis.

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid 180 days from the date of signature.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulations (42 CFE Part 2) prohibits you from further disclosure of lit without the specific written consent of the person to whom it pertains, or otherwise as permitted by such regulations.

Signature of Patient/Legal Guardian _____ Printed name _____ Date _____

If signed by other than patient, indicate relationship: _____