PEARLAND CARDIOVASCULAR ASSOCIATES

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: _____

*NOTE: For requested records in paper format there shall be a charge of no more than $25 for the first twenty pages and $0.50 per page for every copy thereafter. For requested records in electronic format there shall be a charge of $25 for 500 pages or less; $50 for more than 500 pages. For request of copies of imaging studies be $8 per copy, plus additional fee may apply if mailing/shipping/delivery.