AUTHORIZATION TO REQUEST OR RELEASE PATIENT INFORMATION

(Please include a copy of your Driver's License or other form of ID)

Patient's Full Name: _____

Patient's Date of Birth: _____ Patient's Social Security No:_____

Physician Sending Records: Name - _____

Fax - _____

Physician Receiving Records: Name - _____

Fax - _____

I request that the following protected health information be released:

Requested treatment dates: _____

{} Physician office/Progress notes {} Laboratory reports {} Radiology/X-Ray reports {} EKG reports

{} Stress Test reports {} Echo reports {} Medication/Prescription records {} Billing records

{} Other _____

The purpose or reason this information is needed: (check all that apply)

{} Legal purpose {} Insurance {} Personal use {} Medical care {} Military {} School {} Continuity of Care

{} Hospital Pre-op {} Social Security Disability {} Worker's Compensation {} VA Medical Center **(Social Security, Worker's Compensation, & VA Medical Center requests require documentation of a pending claim)**

{} Other _____

I Understand the Following:

* The requested 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 drug or alcohol abuse.

* I have a right to revoke this authorization in writing at any time except to the extent action has been taken in reliance upon this authorization.

* My treatment or payment for treatment cannot be conditioned on my signing this authorization, except in circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

* I may be charged a fee for copies of these medical records according to State and Federal Laws.

* The information released in response to this authorization may be re-disclosed to other parties and can no longer be protected by the sending health care provider.

This authorization will expire 180 days from the date signed below.

_____ _____

Signature of Patient or Legally Authorized Representative Date Signed

Relationship to Patient: _____ Telephone: _____

Heart Center of North Texas Phone: (817) 334-2800 Fax: (817) 820-0094