

# Cardiology Consultants of Houston, L.L.P.

Texas Heart Institute ♦ St. Luke's Episcopal Hospital

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## RELEASE OF RECORDS AUTHORIZATION

I hereby authorize \_\_\_\_\_ to release health records information on:  
Name of Provider who has records

<b>Patient Name:</b>	<b>Date of Birth:</b>
<b>Address:</b>	<b>Social Security #:</b>
	<b>Telephone #:</b>

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For Healthcare Covering the period(s) from: \_\_\_\_\_ to \_\_\_\_\_.

Release to: (Physician's Name)	<input type="checkbox"/> Edward K. Massin, M.D.	<input type="checkbox"/> Mark Schnee, M.D.	<input type="checkbox"/> Jaime Benrey, M.D.
	<input type="checkbox"/> Jorge Garcia-Gregory, M.D.	<input type="checkbox"/> Michael Mihalick, M.D.	

I <input type="checkbox"/> do <input type="checkbox"/> do not (check applicable box) authorize this information to be faxed.	Fax #: <b>713.790.0591</b>
Name of person to receive information:	

This information is being disclosed for the following purpose(s) of:

I understand that if I request copies of records for myself, or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

### INFORMATION TO BE DISCLOSED (check the appropriate box)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Complete health records | <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Consultations   |
| <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> Laboratory Tests        | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Other _____             |  |  |

I understand this material may contain information relating to: Acquired Immunodeficiency Syndrome (AIDS) infection with HIV (Human Immunodeficiency Virus), Mental Health, Alcohol and/or Drug Abuse, Family History, Social History

REVOCATION: I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION FOR THE PURPOSES STATED ABOVE.

UNLESS OTHERWISE INDICATED, THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. THE PHYSICIAN AND EMPLOYEES ARE RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.

I understand there may be a fee for preparing and furnishing this information.

\_\_\_\_\_  
Signature of Patient or Legal Representative      Relationship to Patient      Date