St David's Heart & Vascular

AUTHORIZATION TO RELEASE INFORMATION FROM ST. DAVID'S HEART AND VASCULAR, PLLC.

Patient Name: _____ DOB: _____

Social Security: _____ MRN #: _____

I hereby authorize Austin Heart to release health information on the above named patient to:

Name: _____

Address: _____

City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

Information to be released:

☐ All Austin Heart Records

☐ Treadmill ☐ Echo ☐ Lab Rpt. ☐ Nuclear Report ☐ Vascular

☐ Coumadin ☐ Holter ☐ X-ray Rpt. ☐ ICD/Pacer Rpt ☐ Video/Images

☐ Med. List ☐ Doctor Notes ☐ EKG/ECG

☐ Other (please specify) _____

Date of service records requested from: _____

The above information release is for the purpose of:

☐ Continuity of Care ☐ Insurance ☐ Social Security

☐ Legal/Attorney ☐ Personal/Self ☐ VA Disability

☐ Disability ☐ Other (specify) _____

This authorization will expire 90 days from the date of signature and may be revoked, but not retroactive on records already released in good faith.

PROHIBITION OF REDISCLOSURE: This information is being disclosed to you from confidential records. As their confidentiality is protected by law, you are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains and the facility from which the information originates.

I understand that I am waiving the right of confidentiality of my entire health information, including information related to the diagnosis or treatment of AIDS, AIDS related diseases, psychiatric conditions, child abuse, alcohol and/or drug addiction, which will be released if I sign this authorization.

_____ _____

Signature of Patient or authorized legal representative Date

_____ _____

Relationship to Patient Witness

***NOTE: There may be a charge for request for records.** **WE REQUIRE A 24 HOUR NOTICE FOR STAT REQUEST.**