THE TEXAS HEART INSTITUTE®
CENTER FOR CARDIOVASCULAR CARE
6624 Fannin, Suite 2600 • Houston, Texas 77030 • (713) 790-9401 • Fax Number: (713) 790-0353

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE TEXAS HEART INSTITUTE CENTER FOR CARDIOVASCULAR CARE

Patient Name: _____ Date of Birth: _____

Physician: _____ Phone No: _____

I hereby request your office _____
(Name of physician, insurance company and/or facility)
to furnish a copy of my protected health information to:

The Texas Heart Institute
Center for Cardiovascular Care
6624 FANNIN, STE 2600
HOUSTON, TX 77030

The purpose for release is: _____

Protected health information to be released: (*Please initial where appropriate*)

_____ I authorize the partial release of my medical records to include only the following:
Dates of Treatment: _____
Items to send: _____
(doctors notes, diagnostic tests, medication lists, etc.)

_____ I authorize the release of my complete medical record.

Drug and/or Alcohol abuse, and/or Psychiatric, and/or HIV/AIDS records release

** I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or sensitive information, I agree to its release.
☐ YES ☐ NO _____ Initial

** I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) testing and/or treatment, I agree to its release.
☐ YES ☐ NO _____ Initial

I understand this information will be disclosed to the above party and that its confidentiality is protected by Federal Privacy Laws. I further understand the records will be mailed via the US Postal Service within fifteen (15) business days of this request, and reasonable fees furnished, unless you request your protected health information to be faxed to the third party.

This authorization will expire on _____.
(thirty days from today)

Signature: _____ **Date:** _____
(Patient, Parent or guardian if a minor, or Legal Representative)

Relationship to Patient: _____