AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient:__________________________ **DOB:**___________________ **MRN:** _______

Address:____ **Phone No.:** ______________________

I hereby authorize physicians and representatives of
Memorial Cardiology Associates, PA:

- 915 Gessner Road Suite 900 Houston, TX 77024 office (713) 464-6006 fax (713) 464-0762
- 18400 Katy Freeway Suite 620 Houston, TX 77094 office (281) 398-4944 fax (281) 398-3599
- 1631 N Loop West Suite 520 Houston, TX 77008 office (713) 861-2424 fax (713) 861-5810
- 235 W. Palm Suite 107 Bellville, TX 77418 office (713) 464-6006 fax (713) 464-0762

Email to **medicalrecords@memorialcardiology.com**

- o **To release confidential information to**
- o **To obtain confidential information from**

Name: ____

Address: ____

Phone: ___________________________________ **Fax:** ________________________________

REASON FOR DISCLOSURE:
Please check only one:

- o **Treatment/Continuing Medical Care**
- o **Personal Use**
- o **Insurance**
- o **Legal Purposes**
- o **Disability Determination**
- o **Employment**
- o **Other**

THE FOLLOWING INFORMATION WILL BE:
Please check one: o **Released** o **Obtained**

- o **Entire Records exclude Mental Health**
- o **Nuclear Stress Test Results**
- o **Diagnostic Test Results**
- o **Hospital Records**
- o **Echocardiogram Results**
- o **Other** ______________________________________

EFFECTIVE TIME PERIOD: I understand this authorization is valid for 90 days from the date signed.
FEES: I understand you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information will be charged according to rulings set forth by the Texas State Board of Examiners.
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named on this request. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health and Safety Code§ 181.154© and/or 45 C.F.R § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature:____Date:___________________________________

Printed Name:____Relationship to Patient:____________________