TEXAS CARDIOLOGY ASSOCIATES OF HOUSTON

DIAGNOSIS • INTERVENTION • VEIN CARE

Medical Records Release Form 1/3

I understand Lieber & Moore Cardiology Associates dba Texas Cardiology Associates of Houston is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Texas Cardiology Associates of Houston or its designated employee(s) to disclose my Protected Health Information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

Please allow 7-14 days for copying. **There is a fee of $25.00 for the first 25 pages, $0.50 cents per page after that and postage charges.** The medical records cannot be released until this form is completed and signed by the patient or legal guardian.

You must complete this form thoroughly. Please Print.

First Name: _____ **Last Name:** _____ **M.I.** _____

Social Security Number: _____ *XXX-XX-XXXX* **Date of Birth:** _____ *Month/Day/Year*

I hereby authorize Texas Cardiology Associates of Houston to ☐ **Release** and/or ☐ **Obtain** my health information

Name of Physician & Medical Facility

_____

Physician Phone & Fax Number

_____ _____

Phone # *Fax #*

Physician Facility Address

_____

_____

City _____ **State** _____ **ZIP** _____

1. Description of the information to be used or disclosed (Check as appropriate)

☐ **a. My Entire Record:**

I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical records including, but not limited to: demographic information, patient histories, medication lists, tests and diagnosis. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to (**Check All that Apply**)

☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)

☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment

☐ Genetic Information (including, but not limited to, Genetic Test Results)

NOTE: If you checked "My Entire Record", please skip to number 2.
Otherwise, please continue with "b" and "c"

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1. Description of the information to be used or disclosed CONTINUED

☐ **b. My Demographic Information (Check "All" or those that apply):**

- ☐ All
- ☐ Address
- ☐ Telephone
- ☐ Other: _____
- ☐ Name
- ☐ Gender
- ☐ State/ZIP Code Only
- ☐ Age
- ☐ Race

☐ **c. Medical Date / Information as related to (Check all that apply):**

- ☐ Specific condition(s): _____
- ☐ Specific professional service(s): _____
- ☐ Specific medication(s): _____
- ☐ Alcohol and Drug Abuse Treatment* _____
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment: _____
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS): _____
- ☐ Genetic Information (including, but not limited to, Genetic Test Results) _____
- ☐ Other: _____

2. ☐ **I DO** – or – ☐ **I DO NOT Authorize this information to be disclosed electronically.**

3. Purpose(s) for disclosure of information

Continuation of Medical Care _____

4. Right of Revocation: I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, Texas Cardiology Associates of Houston must receive the revocation in writing and the revocation must include:

a. My name and address
b. The effective date of this authorization and the recipients of the Protected Health Information according to this authorization.
c. My desire to revoke this authorization, and
d. The date of the revocation and my signature

Texas Cardiology Associates of Houston will accept written revocation of this authorization via:

☑ Certified U.S. Mail

☐ Facsimile at this number: _____

All revocations must be sent to Custodian of Medical Records, and are not effective until received by him/her.

5. This authorization shall expire on N/A . After this date/event, Texas Cardiology Associates of Houston can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

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6. I fully understand and accept the terms of this authorization.

Signature of Patient or Legal Guardian

Date Signed (Month / Day / Year)

Printed Name of Patient or Legal Guardian

Relationship to Patient

This information has been disclosed to you from record protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR OFFICE USE ONLY

- ☐ Authorization added to patient's record on
- ☐ Authorization verified by
- ☐ Patient has been provided with a copy of the signed authorization