Fort Worth Heart PA

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Fax back to 817-335-9871 – Questions call 817-271-6067

(Complete all sections of this authorization completely or your request will be delayed)

1. Patient's full name: _____

2. Patient's date of birth: _____ Patient's social security number: _____

3. I authorize **FORT WORTH HEART, P.A.** to disclose the protected health information identified in section (4) below.

4. I request that the following health information be released:
   Date(s) of service/treatment requested: *(check all which apply)*
   Check the box(es) which best describes the information to be released and disclosed.
   - ☐ Physician office/progress notes ☐ Laboratory reports ☐ Radiology/X-ray reports ☐ All records
   - ☐ Medication/prescription records ☐ Consent forms ☐ Echo reports ☐ Billing records
   - ☐ Other _____

5. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric treatment, behavioral or mental health services, and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

6. I request that the health information be released and disclosed to: *(please write legibly)*
   Name (Individual or organization): _____
   Address: _____
   _____ Telephone No: _____

7. The purpose or reason this information is needed: (check all which apply):
   - ☐ Legal Purposes ☐ Insurance ☐ Personal use ☐ VA Medical Center ☐ Military ☐ School
   - ☐ Social Security disability ☐ Workers Compensation ☐ Continuing medical care/treatment
   - **(Social Security, Workers Comp, and VA Medical Center requests require documentation of a pending claim.)**
   - ☐ Other:
   Name of Attorney or Insurance company: _____

8. I have read this authorization in its entirety and understand the following:
   1. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law.
   2. I have a right to revoke this authorization in writing at any time, except to the extent information has already been released in reliance upon this authorization.
   3. The information disclosed in response to this authorization may be re-disclosed to other parties and no longer protected.
   4. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
   5. I may be charged a fee for copies of these medical records according to state and federal laws.

9. This authorization will expire One Hundred Eighty (180) days from the date signed below.

_____ _____
Signature of patient or legally authorized representative — Date signed

Address: _____
(street)

(city) *(state)* *(zip)*

_____ *(H)* _____ *(W)* _____
Relationship of legally authorized representative to patient — Telephone number