WOODLANDS HEART & VASCULAR INSTITUTE

Woodlands Heart & Vascular Institute, P.A.
920 Medical Plaza Drive, Suite 520
The Woodlands, TX 77380
Office: (832)562-3974 Fax: (832) 663-9378 or (281) 771-3542

Authorization for Release of Medical Records

Patient Name: _____ **Date of Birth:** _____

I hereby authorize **Woodlands Heart & Vascular Institute** to ( ) release **TO** ( ) receive **FROM**

_____ _____
Person or Organization Address

_____ _____ _____
Phone Fax City, State, Zipcode

INFORMATION TO BE RELEASED

- ☐ **Complete medical records**
- ☐ Billing Information **Date range: _____ to _____**
- ☐ EKG/Echo Cardiology Report **MOST RECENT**
- ☐ CT Report **Date range: _____ to _____**
- ☐ Labs **MOST RECENT or Date range: _____ to _____**
- ☐ Progress notes **Date range: _____ to _____**
- ☐ Stress Test **MOST RECENT or Date range: _____ to _____**
- ☐ **Other: _____**

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (365 days) from the date of my signature, **unless** specified in writing here: _____. I understand that it may take up to 15 business days for the revocation to take effect. I understand that if the recipient authorized to receive the information is not covered entity, e.g. insurance company of non-health care provider; the released information my no longer be protected by the federal and state privacy regulations.

To the receiving party of this information: This information has been disclosed to you for the sole purpose stating in this consent. Any other use of this information without the expressed written consent of the patient is prohibited. These records may be protected by Federal Regulation (42) CFR, part 2.

_____ _____
Signature of Patient or Legally Authorized Representive **Date**

_____ _____
Printed of Patient or Legally Authorized Representive **Date**

_____ _____
Witness- Printed Name and Signature **Date**