Brian Eades, MD

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Authorization For Release of Medical Information

I hereby authorize the release of any protected health information from my medical records which CareCareTX deems necessary for my cardiology care. I understand the information disclosed my contain information on testing, diagnosis, and/or treatment for HIV, AIDS, sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that my receiving treatment with CorCareTX will not be affected by my refusal to sign this form.

Information to be released:

__History/Physical	__ Progress Notes	__ Discharge Summary
__ Consultation	__ Operative Report	__ Cardiac Cath. Report
__Treadmill Tests	__ EKG/ECG	__ Holter/Event Monitor
__ Lab Reports	__ Chest X-Rays	__ Radiology
__ Echocardiogram	__ Nuclear Scan	__ Vascular Reports
__ Other		

Signature of patient: Date: