



Authorization to Release Health Care information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § '181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Governed entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Patient Name: _____ D.O. B / / SSN: - -

I request and authorize _____ to release the medical records of the patient named above to:

**Trident Heart and Vascular, Southwest Medical Plaza II, 5801 Oakbend Trail, Suite 270, Fort Worth, TX 76132
Ph: (817) 266 0224 Fax: (709) 800-6620**

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- All health information
- History/Physical Exam Past/Present Medications Lab Results Physician's Orders Patient Allergies Operation Reports
- Consultation Reports Progress Notes Discharge Summary Diagnostic Test Reports Billing Information Other

Your initials are required to release the following information:

- Mental Health Records (excluding psychotherapy notes) Genetic information (including Genetic Test Results)
- Drug, Alcohol, or Substance Abuse Records HIV/AIDS Test Results/Treatment

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month ____ Day ____ Year ____

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 under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." 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 & Safety Code 5 181.15a(c) and/or 45 C.F.R. S 16a.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 of Patient or Patient's Authorized Representative

Date Signed

Relationship or status if signed by anyone other than patient (parent, Legal guardian, personal representative, etc.)