Premier
Cardiovascular Care
of Dallas

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ Birth Date: _____
Previous names: _____Social Security#: _____
Mailing Address: _____City: _____ State: _____ Zip: _____
Phone number: _____ Physician Seen: _____

I **(do) (do not)** authorize the following individual or organization listed below to release my records from their practice as described below.

Person, clinic, organization name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

1. Please release my records to **Premier Cardiovascular Care of Dallas:**
   Phone**:** **469-513-2666** Fax: **469-513-2667**

2. The Type of information to be released is as follows: (Please Check)

___ Entire Health Record	___ Operative Procedures	___ Pathology Report
___ History & Physical	___ X-ray/Imaging Reports	___ Echocardiogram
___ Laboratory Reports	___ Billing Records	___ Office Notes

3. Purpose: ◯ Continued Care by Another Provider ◯Insurance Claim ◯Personal Use
   ◯ Social Security Disability ◯ Attorney Review Other

4. I understand the following:
   - My patient health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.
   - Once the records are released to the person, clinic or organization named above, Premier Cardiovascular Care of Dallas cannot prevent them from being sharing my records with a third-party entity.
   - To be valid, this form must be filled out completely and signed. This authorization will expire one year from the date of signing. Unless otherwise specified. _____
     Expiration Date

_____ _____
Date/Time Signature of patient or authorized person (proof required)

Premier Cardiovascular Car of Dallas

(469) 513-2666 Phone
(469) 513-2667 Fax

PROVIDERS

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LOCATIONS

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Duncanville, Texas 75115