AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Medical Record # _____
Date of Birth: _____ Social Security # _____ (optional)

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address: _____

This information may be disclosed TO and used by the following individual or organization:

Dr. Vidyasagar Chodimella, North Texas Heart Care Address: 4325 N. Josey Ln, Plz III, Ste 204 Carrollton, TX 75010
Phone# 972-395-7400, Fax# 972-395-7440

For The Purpose of: Medical Treatment

Please release the following:

_____ Entire Record

Or
- _____ Problem List
- _____ Progress Notes
- _____ History/Physical Exam
- _____ Medication List
- _____ Immunization Record
- _____ List of Allergies
- _____ X-Ray/Imaging Reports: from (date) _____ to (date) _____
- _____ X-Ray Films
- _____ Laboratory Results: from (date) _____ to (date) _____
- _____ EKG Reports
- _____ Genetic Testing Information
- _____ Other Diagnostic Reports (Specify) _____
- _____ Other (Specify) _____

I understand that the information in this health record may include information relating to sexually transmitted disease, Aquired Immunodificiency Syndrome (AIDS), or Human Immunodificiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ **Yes.** I consent to the release of information. ☐ **No.** I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.

I understand that the authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this for in order to ensure treatment. I understand that I may inspect or copy the information to be disclosed, as provided in 45 CFR 164.624. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosed and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the North Texas Heart Care at 972-395-7400.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold North Texas Heart Care liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date Request Completed _____ # Pages Copies _____ Reviewed Only _____ Initials