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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I authorize Woodlands North Houston Heart Center to  Release to  Receive from

Person or Organization Address

Telephone Fax (if applicable)

**PATIENT INFORMATION:**

Last name First name DOB SS #

**INFORMATION TO BE RELEASED** **DATE(S) OF SERVICE:** \_\_\_\_\_

All records  History and physical  Discharge summary  Diagnostic testing

Other \_\_\_\_\_

**THIS INFORMATION IS BEING RELEASED FOR THE FOLLOWING PURPOSE:**

Continued care  Legal  Disability services  Insurance

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 180 days from the date of my signature, unless specified in writing.

I understand that if the recipient authorized to receive the information is not a covered entity, i.e insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

**TO THE PARTY RECEIVING THIS INFORMATION:**

This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulation (42 CFR Part 2) prohibit you from making any further disclosure without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

**FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFW Part 2:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Patient or Legally Authorized Representative**

\_\_\_\_\_

**Relationship to Patient**

\_\_\_\_\_

**Print Name of Legally Authorized Representative**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness – Print Name/Signature**

\_\_\_\_\_

**Patient or Legally Authorized Representative Drivers License #**