

# Woodlands-North Houston Heart Center

## PATIENT INFORMATION FORM

Patient Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (m/i) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Female  Male DOB: \_\_\_\_\_ Social Security# \_\_\_\_\_

Patient Status:  Single  Married  Divorced  Separated  Widowed  Minor / Student

Are you Employed?  Yes  No Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Spouse Name: \_\_\_\_\_ DOB \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Employed  Yes  No (where) \_\_\_\_\_

### TELEPHONE INFORMATION:

Home: \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_ Cell \_\_\_\_\_

In the event of an emergency, who should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Contact# \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION ABOUT PATIENT'S CONDITION/TREATMENT

Dear Patient,

In accordance with the Medical Privacy Act of Texas, Physicians and/or staff of Woodlands-North Houston Heart Center, are unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release and/or obtain information regarding your care to someone other than yourself, please complete the following authorization.

**I hereby authorize Physician's and/or staff of Woodlands-North Houston Heart Center, to release information pertaining to my condition and/or care to only those family members, physicians and/or others involved with my care as listed below:**

\_\_\_\_\_  
Name Relationship Telephone Number

\_\_\_\_\_  
Name Relationship Telephone Number

\_\_\_\_\_  
Name Relationship Telephone Number

\_\_\_\_\_  
Name Relationship Telephone Number

\_\_\_\_\_  
**Patient Signature**

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

If not signed by patient, please indicate relationship:  Minor  Legal Guardian/patient incompetent