TEXAS INSTITUTE OF CARDIOLOGY, P.A.
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5313 WEST UNIVERSITY DRIVE
MCKINNEY, TEXAS 75071
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Authorization to Release Health Care Information

Name: ____ **Date of Birth:** ___________________________

Previous Name: ____ **Social Security Number:** ___________________

I request and authorize ____ **to release health care information of the patient named above to:**

Texas Institute of Cardiology
5313 West University Dr
McKinney, TX 75071
214-544-7555
Fax: 214-544-6769

___ **Copies of the complete history records in your possession concerning my illness and/or treatment to include:**

___**EKGs** ___**All Lab Work** ___**All Cardiac Procedures**

We will not disclose your Medical information for any purpose except for treatment, payment and healthcare operations. Any specific written authorization you provide may be revoked at any time by writing us. I am confirming my authorization for use and/ or disclosure of the protected health information described in this form with the people and/ or organizations named in this form.

Patient Signature: ____ **Date:** _____________________

Name if individual is not Patient: ____ **Relationship to Patient:** ____________