

VITAL

HEART & VEIN

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ DOB: _____

SSN: _____ Previous Name: _____

I request and authorize _____ to release health care information of the patient named above (by mail or fax) to Vital Heart & Vein, PLLC:

- 6400 Fannin, Ste. 2210-B, Houston, TX 77030 | Fax: 713.796.9300
- 18955 Memorial Dr. N., Ste. 580 & 250, Humble, TX 77338 | Fax: 281.446.6657
- 22999 US Hwy. 59, Ste. 210, Kingwood, TX 77339 | Fax: 281.359.5888
- 10907 Memorial Hermann Dr., Ste. 370, Pearland, TX 77584 | Fax: 832.486.9953

This request and authorization applies to:

- Health care information relating to the following treatment, condition, or dates of treatment:

- All health care information

- Others: _____

I understand that my express consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, pregnancy, psychiatric disorder/mental health, or drug and/or alcohol use.

If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, pregnancy, psychiatric disorder/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

I hereby authorize Vital Heart & Vein to release any or all information acquired in the course of my examination and/or treatment. I understand that this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another physician or health care facility to which the patient may be transferred or referred.

Signature of Patient or Patient's Authorized Representative

Date Signed

Relationship or Status: _____

If signed by anyone other than the patient - parent, legal guardian, personal representative, etc.