The Heart Smart Group

Medical Records Release Authorization

Patient Name:_____Date of Birth:_____

Address:_____

Social Security #_____Phone #_____

The following person or facility is authorized to provide copies of the patient's identifiable health information:

RELEASE FROM: Name:_____

Address: _____

Phone: _____ Fax: _____

SEND TO: **The Heart Smart Group, 4510 Medical Center Drive, Suite 209, McKinney, TX 75069**
Phone: (469) 440-2570 Fax: (214) 548-5667

Purpose for releasing the information:

☐ Moving Away from Area ☐ Transfer of Care ☐ At request of Patient ☐ For Patient Care

Describe the information that is to be released:

☐ Office / treatment notes ☐ Lab Reports ☐ X-ray /CT reports ☐ EKG
☐ Other:_____

Indicate the dates of service that is to be released:

☐ Entire medical records for services rendered at this office.

☐ Last office visit, laboratory and/or x-ray test results

☐ Other (please specify) _____

- I understand that if my records contain documentation of alcohol abuse, psychiatric conditions, drug abuse, or communicable diseases, this information will be released as part of my record.
- I understand that if the person or facility receiving this information is not covered by federal privacy policy regulations, this information will no longer be protected and may be re-disclosed.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. (Note: the revocation must be in writing and delivered to the person/office that was to be authorized to release information.
- I understand that this authorization will expire thirty (30) days from the date signed and no longer be valid.
- I understand that there may be a charge for obtaining the requested records and that I will be responsible for payment of such charges.
- I understand that I have a right to obtain a copy of this authorization.

PATIENT SIGNATURE:_____DATE:_____