Texas Cardiology Associates of Houston

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Patient Authorization to Release Medical Information

Patient Name:____ Date of Birth:________

I understand that my family members, friends and co-workers may ask questions about my medical condition to include test results, appointments and billing information over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my physician or physician's staff to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties listed below with whom I wish Texas Cardiology Associates of Houston to be able to discuss my medical condition to include test results, appointments and billing information. I hereby authorize Texas Cardiology Associates of Houston to discuss and release my medical information to the following individuals:

____________________________ ____________________ ____________________
Name Relationship Phone #

____________________________ ____________________ ____________________
Name Relationship Phone #

Is it ok to leave results on an answering machine? YES☐ NO☐

The below individuals are authorized to pick up any written prescriptions, medication samples or testing films on my behalf:

____________________________ ____________________
Name Relationship

____________________________ ____________________
Name Relationship

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded:

____

____ ____________________________
Name of Patient (please print) Date

____ ____________________________
Signature of Patient or Guardian Relationship to Patient

This authorization will be effective until revoked in writing by patient listed above.