NORTH TEXAS HEART CENTER

DISCLOSURE OF
CONFIDENTIAL HEALTH INFORMATION

I HEREBY REQUEST THE DISCLOSURE OF MY INDIVIDAULLY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW, WHICH MAY INCLUDE INFORMATION CONCERNING COMMUNICABLE DISEASES SUCH AS HUMAN IMMUNODEFICIENCY VIRUS ("HIV") AND ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS"), BEHAVIORAL AND MENTAL HEALTH (EXCEPT FOR PSYCHOTHERAPY NOTES), CHEMICAL OR ALCOHOL DEPENDENCY, LABORATORY TEST RESULTS, MEDICAL HISTORY, TREATMENT, OR ANY OTHER SUCH RELATED INFORMATION.

_____
Print Patient Name Date of Birth Social Security Number

_____Address

AUTHORIZES:

Physician/Clinic: _____

Address: _____

Description of information to be released: (check all that apply)

___History & Physical ____Consultation reports ____Radiology films __Other:_____

___Nurse's notes ___Physician's orders ___Cardiology tests _____

___Progress notes ___Hospital records ___Laboratory reports _____

___Radiology reports ___EKG reports

Description of the purpose for use and/or disclosure: Continuation of Care

The health information described herein shall be released to: **NORTH TEXAS HEART CENTER**

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.
I further understand that I may revoke this authorization in writing at any time prior to the expiration date. However, this will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient

_____
Representative Relationship to Patient

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