Waco Cardiology Associates Authorization
To Use or Disclose Medical Records/Health Information

By signing this form, I hereby authorize _____
to release medical information regarding my care and treatment as provided in this authorization. I understand that this authorization applies to all records created in the course of my treatment as listed below, including information regarding my medical condition and treatment, mental health, alcohol/drug abuse diagnosis and treatment and communicable disease status, including AIDS/HIV.

Patient Name: _____

D.O.B. _____ Social Security #: _____

Information to be Disclosed:

( ) Records of ALL visits (complete record)
( ) Record of visit for a specific date or dates. Specific dates include _____
( ) Progress Notes Only
( ) Test Results Only
( ) Billing Information
( ) Review, Request and/or Verbally Exchange Medical/Billing Information
( ) Other (specify) _____

Person/Organization to Whom the Information Will be Disclosed:

Name: _____

Address: _____

City, State, Zip: _____

Information will be disclosed by: ( )Mail ( )Pick Up ( )Fax _____

Purpose of Disclosure: ( )Treatment ( )Legal ( )Payment ( )Other _____

I hereby give this authorization freely with the understanding that:

- I may revoke this authorization in writing at any time by completing a revocation form available at Waco Cardiology Associates, except to the extent that information has already been released
- If not previously revoked, this authorization will expire one year after the date of my signature
- Waco Cardiology Associates may not condition the provision of treatment upon my signing this authorization, except that it may condition the provision of treatment-related research on the provision of an authorization for the use or disclosure of information for such research
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by law
- Waco Cardiology Associates, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein
- A photocopy or facsimile of this authorization is valid as the original

_____ _____
Signature of Patient/Legally Authorized Representative Date

_____
Relationship if Legally Authorized Representative