AUTHORIZATION TO RECEIVE & RELEASE PERSONAL HEALTH CARE INFORMATION TO & FROM VITAL HEART & VEIN

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

I request and authorize _____ physician, physician group, and/or healthcare system and Vital Heart & Vein to exchange my personal protected health care information. Incoming medical records may be mailed or faxed to:

Vital Heart & Vein, PLLC
Attn: Medical Records Department
18450 Hwy 59 N.
Humble, TX 77338

Phone: 281-446-6656
Fax: 281-446-6657

I understand that my expressed consent is required to release any healthcare 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: _____ Date: _____
(Patient, Parent or Guardian if a minor, or Legal Representative)

Relationship to Patient: Self