VITAL

HEART & VEIN

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name:_____ DOB:_____

SSN:_____Previous Name:_____

I request and authorize _____ to release health care information of the patient named above (by mail or fax) to Vital Heart & Vein, PLLC:

- ☐ 18450 Hwy 59, Humble, TX 77338 | Fax: 281.446.6657
- ☐ 6400 Fannin, Ste. 2210-B, Houston, TX 77030 | Fax: 713.796.9300
- ☐ 10907 Memorial Hermann Dr., Ste. 370, Pearland, TX 77584 | Fax: 832.486.9953

This request and authorization applies to:

- ○ Health care information relating to the following treatment, condition, or dates of treatment:

  _____

- ○ All health care information
- ○ Others:_____

I understand that my express consent is required to release any health care 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 of Patient or Patient's Authorized Representative Date Signed

_____

Relationship or Status:

If signed by anyone other than the patient - parent, legal guardian, personal representative, etc.