# TEXAS CARDIOVASCULAR INSTITUTE

***Authorization to Release Information***

Patient's Name: _____ Date of Birth: ___/___/____

Patient's Social Security Number: _____

I hereby authorize [Texas Cardiovascular Institution] to (check one): _____ obtain from the following

_____ release to the following

Name: _____

Address:_____

_____

the following documents/information from the records pertaining to services received

Date of Service:

The documents to be released are described or listed as:

The records are required for the specific purpose of:

I understand that my authorization will remain effective from the date of my signature until _____ _____, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

_____ _____

Signature of Patient / Patient's Designated Representative Date

_____ _____

Witness Date