CARDIAC CENTER OF TEXAS, PA
VEIN & VASCULAR CLINIC OF TEXAS

4201 MEDICAL CENTER DRIVE #380
MCKINNEY, TX 75069

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release health care information of the patient named above **to/from**:

Cardiac Center of Texas — CLINIC/MD: _____

Vein & Vascular Clinic of Texas — ADDRESS: _____

(972) 529-6935 fax — PHONE/FAX: _____

☐ Copies of the complete history and records in your possession concerning my illness and/or treatment to include:

☐ EKGs ☐ ALL LAB WORK ☐ ALL CARDIAC/VASCULAR TESTS/PROCEDURES

I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Patient Signature: _____ Date Signed: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Printed Name: _____

Personal Representative's Signature: _____

Relationship to Individual Patient: _____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.