MEMORIAL KATY
CARDIOLOGY ASSOCIATES

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Houston, TX 77043

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18400 Katy Fwy, Suite 600
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

I, _____, hereby authorize the release of any protective health information my medical record which Memorial Katy Cardiology Associates deems necessary for my cardiology care. I understand the information disclosed may contain information on testing. diagnosis and/or treatment of HIV. AIDS, STD. mental health/ psychiatric disorders, and drug or alcohol use. I understand that this authorization is voluntary, and I may refuse to sign it.

I authorize the disclosure of any information governed by HIPAA to be provided to the following persons:

TO:
PHONE:
FAX:

FROM:
PHONE:
FAX:

INFORMATION TO BE RELEASED:

- ☐ History / Physical
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Consultations
- ☐ Operative Report
- ☐ Cardiac Cath Reports
- ☐ Treadmills
- ☐ EKG/ECGs
- ☐ Holter/ Event Monitors
- ☐ Lab Results
- ☐ Chest X-Ray
- ☐ Radiology Reports
- ☐ Echocardiograms
- ☐ Nuclear Stress Reports
- ☐ Vascular Reports
- ☐ Other (Please specify) _____

This authorization will expire 180 days from the date of signature and may be revoked. but not retroactively on records already released in good faith.

_____ _____
(Signature of Patient/Legal Representative) ***(Date)***

Please note there may be a fee required for records. Payment is due at time of request

Print Form Reset Form

Modified: 08/12/2020