MEMORIAL KATY
CARDIOLOGY ASSOCIATES

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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:

DOCTOR / FACILITY: _____
PHONE NUMBER: _____ **FAX NUMBER:** _____

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