WOODLANDS NORTH HOUSTON
HEART CENTER

Vincent Aquino, M.D., F.A.C.C. Gary M. Coleman, M.D., F.A.C.C. Bruce S. Lachterman, M.D., F.A.C.C.

Christopher H. LaVergne, M.D., F.A.C.C. Brenda K. Peabody, M.D., F.A.C.C. Bernardo de la Guardia, M.D., F.A.C.C.

Chacko Alexander, M.D., F.A.C.C. Margit Nemeth, M.D., F.A.C.C. George Kantis, M.D., F.A.C.C.

Kedar Vaidya, M.D.,F.A.C.C. Christopher Nguyen, M.D.

Julia Manning, MSN, ACNP-BC Barbara Kimmons, PA-C

P.O. Box 73627 Houston, TX 77273-3627

Tel 281-444-3278 Fax 832-249-3850

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Woodlands North Houston Heart Center to ☐ Release to ☐ Receive from

_____

Person or Organization Address

_____

Telephone Fax (if applicable)

PATIENT INFORMATION:

_____

Last name First name DOB SS #

INFORMATION TO BE RELEASED **DATE(S) OF SERVICE:** _____

☐ All records ☐ History and physical ☐ Discharge summary ☐ Diagnostic testing

☐ Other _____

THIS INFORMATION IS BEING RELEASED FOR THE FOLLOWING PURPOSE:

☐ Continued care ☐ Legal ☐ Disability services ☐ Insurance

☐ Other: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire 180 days from the date of my signature, unless specified in writing.

I understand that if the recipient authorized to receive the information is not a covered entity, i.e insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION:

This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulation (42 CFR Part 2) prohibit you from making any further disclosure without specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFW Part 2:

_____ **Date:** _____

Signature of Patient or Legally Authorized Representative

_____

Relationship to Patient

_____

Print Name of Legally Authorized Representative

_____ **Date:** _____

Witness – Print Name/Signature

_____

Patient or Legally Authorized Representative Drivers License #