HEARTPLACE
US HEART & VASCULAR

AUTHORIZATION FOR RELEASE OF INFORMATION TO HEARTPLACE

Submit Request To: _____

1. I hereby consent to the release and transfer **TO**: **Name**: HeartPlace Glen Rose

Address: 1008 NE Big Bend Trail, Suite 400

City: Glen Rose **State**: TX **Zip**: 76043

Phone: 254-897-1434 **Fax:** 254-897-1409

the following information from its records on: **Patient's Name**: _____

DOB: _____ **SS#**: _____

SPECIFY INFORMATION:

2. The above information is released for the following purpose and that purpose only. **Other uses are prohibited.**

_____

3. I understand that the specific information to be released may include, but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data.

4. I understand that I may revoke this Authorization at any time by notifying HeartPlace in writing, but if I do, it will not have any effect on any actions HeartPlace too, including any uses or disclosures of my Protected Health Information made by HeartPlace, before it received the revocation of this Authorization.

5. I understand that if my Protected Health Information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

6. I understand that I have a right to inspect and copy my own Protected Health Information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

7. I authorize faxing the information to be disclosed to the requesting party ☐ Yes ☐ No

8. I have read and understand this consent and I have signed it voluntarily and of my own free will.

9. This authorization will expire ninety (90) days from the date of signature.

_____	_____	_____
Patient/Care Giver Signature	Relationship to Patient	Date Signed
_____	_____	_____
Witness Name	Witness Signature	Date Signed

PROHIBITION ON REDISCLOSURE: The following information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit the redisclosure of the information without the written consent of the person to whom it pertains unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.