Board Certified, Pediatric Cardiology

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Pediatric Cardiology Associates of Houston

Phone (281) 661-8460
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Release of Medical Records

Name of doctor/facility:_____

Address of doctor/facility:_____

Phone number of doctor/facility:_____

Please release medical records for the following patient to ***Pediatric Cardiology Associates of Houston***. These records may be faxed or mailed.

Patient name:_____

Patient address:_____

Patient date of birth:_____

Purpose of disclosure:

_____Medical care _____Attorney _____Personal use

_____Insurance _____Other_____

This authorization covers patient care from _____ to _____.
Date Date

I agree that a photocopy or fax copy of this authorization may be considered valid.

_____Yes _____No

I understand this authorization will expire 90 days from the date of my signature.
I understand I may revoke this authorization at any time by notifying the providing organization in writing. If I do, it will not affect any action taken before they received the revocation.
I understand that my records are protected under state and federal law. I also understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information.

_____
Printed name of patient/parent/guardian

_____
Signature of patient/parent/guardian

_____ _____
Date Phone number(s)

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PEDIATRIC
Cardiology Associates of Houston
Diagnosis & Treatment of Cardiology Disorders
Fetal/Neonatal through Young Adults

Christine A. Glasow, MD
Clarisa Y. Garcia, MD
Maria C. Yates, MD

Authorization for Disclosure of Confidential Information

I authorize ***Pediatric Cardiology Associates of Houston*** to release information on me/my son/my daughter/my grandchild to:

Name of doctor/facility:_____
Address of doctor/facility:_____
Phone number of doctor/facility:_____
Patient name:_____
Patient address:_____
Patient date of birth:_____
Purpose of disclosure:

_____Medical care _____Attorney _____Personal use

_____Insurance _____Other_____

This authorization covers patient care from _____ to _____.
Date Date

I agree that a photocopy or fax copy of this authorization may be considered valid.

_____Yes _____No

I understand this authorization will expire 90 days from the date of my signature.
I understand I may revoke this authorization at any time by notifying the providing organization in writing. If I do, it will not affect any action taken before they received the revocation.
I understand there will be a fee for copying and releasing my records and that such fee is in accordance with state and federal guidelines.
I understand that my records are protected under state and federal law.
I also understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information.

_____
Printed name of patient/parent/guardian

_____
Signature of patient/parent/guardian

_____ _____
Date Phone number(s)

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