## Waco Cardiology Associates Authorization To Use or Disclose Medical Records/Health Information

By signing this form, I hereby authorize
Patient Name:
D.O.BSocial Security #:
Information to be Disclosed:
( ) Records of ALL visits (complete record) ( ) Record of visit for a specific date or dates. Specific dates include ( ) Progress Notes Only ( ) Test Results Only ( ) Billing Information ( ) Review, Request and/or Verbally Exchange Medical/Billing Information ( ) Other (specify)
Person/Organization to Whom the Information Will be Disclosed:
Name:
Address:
City, State, Zip:
Information will be disclosed by: ( )Mail ( )Pick Up ( )Fax
Purpose of Disclosure: ( )Treatment ( )Legal ( )Payment ( )Other
I hereby give this authorization freely with the understanding that:
<ul> <li>I may revoke this authorization in writing at any time by completing a revocation form available at Waco Cardiology Associates, except to the extent that information has already been released</li> <li>If not previously revoked, this authorization will expire one year after the date of my signature</li> <li>Waco Cardiology Associates may not condition the provision of treatment upon my signing this authorization, except that it may condition the provision of treatment-related research on the provision of an authorization for the use or disclosure of information for such research</li> <li>Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by law</li> <li>Waco Cardiology Associates, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein</li> <li>A photocopy or facsimile of this authorization is valid as the original</li> </ul>
Signature of Patient/Legally Authorized Representative Date
Relationship if Legally Authorized Representative