**Acclaimed Heart and Vascular Center, PA** **281-290-0222 Voice**
**Arsalan Shahzad, MD** **281-290-0233 Fax**

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

**I authorize Acclaimed Heart and Vascular Center:** ( ) release to: ( ) receive from:

_____

**Person or Organization** **Address**

_____

**Phone** **Fax (If applicable)**

Information / copies form the medical records on:

_____

**Patients Name** **Date of Birth** **SS#**

_____

**Date(s) of Service**

**INFORMATION TO BE RELEASED: Circle**

EKG REPORT LABS ECHO
STRESS REPORT LAST NOTE CARDIO STUDY
Other_____

**This information is being released for the following purpose: Circle**

Continued Care Attorney / Litigation Insurance Disability Services
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 here_____

I understand that if the recipient authorized to receive the information is not covered entity, e.g. insurance company of non-health care provider; the released information may no longer be protected by the 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 regulations (42 CFR Part 2) prohibit you 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 CFR PART 2

_____ _____
Signature of Patient of Legally Authorized Representative Date

_____ _____
Printed Name of Legally Authorized Representative Relationship of Patient

_____ _____
Witness - Printed Name / Signature Date

_____
Patient or Legally Authorized Representative Driver's License / ID#