LONESTAR HEART AND VASCULAR

479 Oxford Dr. Ste. 104
New Braunfels, TX 78130
Phone: 830-214-0300
Fax: 830-214-0397

Authorization to Obtain/Disclose Protected Health Information

PATIENT IDENTIFICATION

Printed Name:_____ **Date of Birth:**_____

Address:_____ **Telephone:**_____

_____

I, the undersigned, authorize the release of the requested access to the information specified below from the medical record, protected health information from the above-named patient.

Covering periods of health care from (date):_____ **to (date)** _____

PURPOSE OF REQUEST (CHECK ONE)

□ **Transition of Care** □ **At the request of the Patient** □ **Billing or Claims Payment**

□ **Other (please specify):**_____

INFORMATION TO BE RELEASED OR ACCESSED

□ **Complete health record**	□ **Face sheet**	□ **Consultation report**
□ **History & physical exam**	□ **Lab/Pathology report**	□ **Emergency room report**
□ **Operative report**	□ **Discharge summary**	□ **Radiology report**

Send and/or release information via: □ **Fax** □ **Mail**

I authorize Lone Star Heart & Vascular to (check one):

□ **Obtain confidential information from** **OR** □ **Release confidential information to:**

Name:_____

Address:_____

City/State/Zip:_____

Phone:_____ **Fax:**_____

- **I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. The information obtained or disclosed pursuant to this authorization may be subject to redisclosure, and I hold Lone Star Heart & Vascular and/or its representatives harmless from liability resulting in the release or obtaining of the above protected health information.**
- **I understand that I may revoke this authorization in writing at any time prior to release of the protected health information specified above.**
- **I understand that the specified information to be released may include but not limited to: history, diagnoses, and/or treatment of drug and alcohol abuse or use, psychiatric treatment, mental illness, communicable diseases which are protected by Federal Law 42CFR Part II.**
- **I understand that I may be charged a fee for copies of my records/protected health information according to Texas Hospital Licensing Law.**
- **This authorization will expire 180 days from the date of my signature unless revoked prior to that time.**

Signature of Patient/Responsible Party:_____ **Date:**_____