

**Authorization to Obtain or Release of Medical Records  
From Medical Providers**

I authorize **Cypress Cardiology, P.A.** ("the Practice") to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid, and any insurance company, third party administrator or managed Care Company.

X \_\_\_\_\_  
*Patient Signature*

X \_\_\_\_\_  
*Date*

X \_\_\_\_\_  
*Printed Name*

X \_\_\_\_\_  
*Date of Birth*

**Authorization to Release Medical Information to  
Individuals/Family Members**

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of the Practice to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

\_\_\_\_\_ I do not authorize the Practice to release any or all information concerning my medical care or finances to any individual except as set forth above.

\_\_\_\_\_ I authorize the Practice to verbally release any or all information concerning my medical care or finances to the following individuals:

X \_\_\_\_\_  
*Name*

X \_\_\_\_\_  
*Relationship to Patient*

X \_\_\_\_\_  
*Name*

X \_\_\_\_\_  
*Relationship to Patient*

X \_\_\_\_\_  
*Patient Signature*

X \_\_\_\_\_  
*Date*

X \_\_\_\_\_  
*Witness*

X \_\_\_\_\_  
*Date*

**Medical Records Release Form**

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below or otherwise release confidential information.

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Complete Record**

**Records of care from the following dates:** \_\_\_\_\_ **to** \_\_\_\_\_

**Records concerning the following conditions:** \_\_\_\_\_

**Other, please specify:** \_\_\_\_\_

**Confer with person(s) listed below orally about my medical information**

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Release to the following person(s):**

**Name:** Cypress Cardiology, P.A.  
**Address:** 21212 Northwest Freeway, Suite 405  
Cypress, Texas 77429  
**Phone:** (281) 890-8588      **Fax:** (281) 894-0426

**The reason or purpose for this release of information is as follows:**

\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas State Board of Medical Examiners.**