

Patient Information

Patient Name _____
Address _____
City _____ **State** _____ **Zip** _____ **Sex** _____ **Age** _____
Home Phone Cell/Pager _____
SSN _____ **Birthdate** _____ **Marital Status: S M W D** _____
Driver's License _____ **State Issued** _____

Patient Employer _____ **Work No.** _____
Address _____ **Occupation** _____
City _____ **State** _____ **Zip** _____

Spouse _____ **Name** _____ **SSN** _____ **Birthdate** _____
Employer _____ **Work No.** _____
Nearest Relative _____ **Relationship** _____ **Phone No.** _____
Referred by _____

Insurance Information

Guarantor Name _____ **SSN** _____ **Birthdate** _____
Primary Insurance _____ **Phone No.** _____
Address _____ **City** _____ **State** _____ **Zip** _____
ID No. _____ **Group No.** _____ **Insured** _____

Guarantor Name _____ **SSN** _____ **Birthdate** _____
Primary Insurance _____ **Phone No.** _____
Address _____ **City** _____ **State** _____ **Zip** _____
ID No. _____ **Group No.** _____ **Insured** _____

I hereby authorize Thomas L. DeBauche, M.D. to furnish information to insurance carriers concerning my illness and treatments and hereby assign all insurance benefits payable for services rendered to my dependents or myself.

Date _____ **Signature** _____

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

I authorize **Thomas L. DeBauche, M.D., F.A.C.C., dba Cypress Fairbanks Cardiology Associates** ("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: Thomas L. Debauche. M.D., F.A.C.C.
Street: 11301 Fallbrook Dr. Ste. 130
City: Houston **State:** TX **Zip:** 77065
Telephone: (281) 890-8588 **Fax:** (281) 894-0426

The reasons or purpose for this release of information are 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 rulings set forth by the Texas State Board of Medical Examiners.