Leachman Cardiology Associates, P.A.
AN AFFILIATE OF TEXAS HEART INSTITUTE

D. Richard Leachman, M.D.
Roberto Lufschanowski, M.D.
Paolo Angelini, M.D.
Zvonimir Krajcer, M.D.
Alberto Lopez, M.D.
Stephanie Coulter, M.D.
Eduardo Hernandez, M.D.

6624 Fannin • Suite 2780 • Houston, Texas 77030 • (713) 790-9401 • Fax: (713) 790-0353
www.leachmancardiology.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM LEACHMAN CARDIOLOGY ASSOCIATES

Patient Name: _____ Date of Birth: _____

Physician: _____ Acct # (if known):_____

I hereby request Leachman Cardiology Associates to furnish a copy of protected health information to:

_____

(Name of physician, insurance company and/or facility that records will be provided)

_____ _____ _____

Street Address City, State, Zip Phone

The purpose for release is: _____

Protected health information to be released: (Please initial where appropriate)

_____ I authorize the partial release of my medical records to include only the following:

Dates of Treatment: _____

Items to send: _____
(doctor notes, diagnostic tests, medication lists, etc)

_____ I authorize the release of my complete medical record.

If you wish to have your records faxed to the third party indicated above, please provide a fax number. Please note that if protected health information is faxed, the fax may or may not be secure.

Please fax to fax number: _____

I understand this information will be disclosed to the above party and that its confidentiality is protected by Federal Privacy Laws. I further understand the records will be mailed via the US Postal Service within fifteen (15) business days of this request, and reasonable fees furnished, unless you request your protected health information to be faxed to the third party.

This authorization will expire on _____.
(thirty days from today)

Signature: _____ Date: _____
(Patient, Parent or guardian if a minor, or Legal Representative)

Relationship to Patient: _____

OFFICE USE ONLY

Request/Records Sent: _____ Signature: _____