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

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

Patient Name: ____ Date of Birth: ______________________

I hereby request your office ____
(Name of physician, insurance company and/or facility)

____
Street Address | City, State, Zip | Phone/Fax

to furnish a copy of my protected health information to:

LEACHMAN CARDIOLOGY ASSOCIATES, P.A.
6624 FANNIN, STE 2780
HOUSTON, TX 77030

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.

Drug and/or Alcohol abuse, and/or Psychiatric, and/or HIV/AIDS records release

** I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or sensitive information, I agree to its release. __________ YES __________ NO (check one and initial)

** I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) testing and/or treatment, I agree to its release. __________ YES __________ NO (check one and initial)

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: ____