Frisco Heart and Vascular Institute

8000 Warren Pkwy # 104
Frisco, TX 75035
469-362-6543 Fax 469-362-6545

AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

1. Patient Name:_____

   Date of Birth: _____ Phone#:_____

   Persons/organization(s) **providing** records: **(Complete address/phone#)**

   _____

   _____

   _____

   _____

   Persons/organization(s) **receiving** records:

   _____

   _____

   _____

   _____

   Covering all periods of care from:_____ to _____

2. **Information to be released:**

   _____Copy of complete medical record
   _____ History and physical
   _____EKG report
   _____Stress Test
   _____Echocardiogram
   _____Holter report
   _____ _Other_____

3. **Purpose of Disclosure: _____to send to insurance company**
   _____to send to new general physician
   _____to transfer care to a new cardiologist

4. **I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.**

5. **Specification of the date, event of condition upon which this consent expires:**
   _____

6. **The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.**

Signed: _____ Date:_____
Patient or Representative

_____
Relationship to Patient