Heart of Texas Cardiology, P.A.
2911 Medical Arts Street, Bldg. 10
Austin, Texas 78705
512-474-5551

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (Please Print)

Patient Name: _____

Date of Birth: _____ SSN: _____

Home Address: _____

Mailing Address: _____

Home Phone #: _____ Work Phone#: _____X_____

Records Released **From**:

_____
Physician or Clinic Name

_____
Address

_____
City, State, Zip

_____
Phone Number

_____
Fax Number

Records **Released To:**

David W. Hayes, M.D.

2911 Medical Arts Street, Bldg. 10

Austin, Texas 78705

Phone: 512-474-5551

Fax: 512-474-7324

Please release the following for date(s) of treatment from: _____

☐ History & Physical
☐ Treadmill Reports
☐ Echo
☐ Laboratory Reports
☐ Nuclear Reports
☐ Holter Reports
☐ EKG (s)
☐ Hospital/Operative Report(s)
☐ Other (please specify) _____

PURPOSE OR NEED FOR DISCLOSURE:

☐ Transfer of Care ☐ Continuation of Care

I hereby authorize the release of my medical records, including all results and tests that may include the following data: drug, alcohol, and psychiatric treatment to party noted above. I understand that I may revoke this authorization at any time except to the extent that the action has been taken in reliance on it. This authorization will expire in one year from the date of my signature or as otherwise specified by date or events of conditions as follow: _____.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date