THE HEART INSTITUTE
OF EAST TEXAS, P.A.
Specializing in Heart & Vascular Care Since 1982.

Medical Records Release Form

To: ____
Doctor or Hospital

____
Address

I hereby authorize and request you to release to:

Name: ____

Address: ____

Phone: ______________________________ Fax: ________________________________

The complete medical records in you possession concerning my illness and/or treatment:

Records Requested: ____

Time Period: ______________________________ To: ______________________________

Reason for release: ____

I understand that this authorization authorizes the release if all medical rerecords including psychiatric, alcohol, drug abuse, and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, section408: Public Law 93-282, Section 333: federal Regulation 421 CFR, Part 2. The information provided is confidential and any disclosure by the recipient is prohibited.

______________________________	______________________________
Patient or Nearest Relative	Relation to Patient
______________________________	______________________________
Witness	Date
______________________________	______________________________
Printed name of patient	Patient's date of birth
	______________________________
	SSN

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