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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