Authorization for Medical Record Release

(For Pediatric Heart Care patients to request to send medical records to self, another provider or outside entity)

1. I hereby authorize Pediatric Heart Care (PHC) to use and disclose protected health information from the record(s) of:
   a. Patient Name: _____ DOB: _____
   b. MRN (if applicable): _____ Phone No: _____
2. Copies of following records shall be used and disclosed:

   ☐ Clinic Notes ☐ Echocardiogram Report ☐ ECG Report

   ☐ Radiology Results ☐ Echocardiogram Images ☐ Lab Results

   ☐ Consultation Notes ☐ Outside Facility Records ☐ Genetics

   ☐ Discharge Summary ☐ Other: _____
3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus ("HIV") infection and Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.
4. I understand that copies of indicated records will be sent to:

   ☐ Send to:

   Name of Recipient: _____

   Name of Company: _____

   Address: _____

   _____

   ☐ Fax to (this can only be done to send to medical offices or healthcare facilities):

   Name of Recipient: _____

   Name of Clinic/ Facility: _____

   Address: _____

   _____

   Fax No: _____ Phone No: _____
5. I understand that there may be a fee assessed for these records.
6. I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.
7. Purpose of the disclosure is (are): _____

   _____
8. I understand that I may revoke this authorization in writing at any time except to the extent that PHC has already relied on this authorization. I may revoke this authorization by sending a written notice to PHC at 2955 Harrison Ave, Suite 100, Beaumont TX 77702.
9. Unless otherwise revoked, this authorization will expire on the 180th day of signifying or otherwise specified here: _____ (revocation date).
10. I understand that PHC may not condition treatment on my completion of this authorization form.

Signature of Patient/ Patient's Legal Representative: _____

Name of Patient/ Patient's Legal Representative: _____

Relationship to the patient (if minor): _____

Date signed: _____