

CARDIOLOGY CONSULTANTS OF TEXAS

Diagnostic and Interventional Cardiology

RELEASE OF MEDICAL INFORMATION

MEDICAL RECORDS FAX: 214-237-6556

CCT PHYSICIANS

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TO WHOM IT MAY CONCERN:

I, _____, am authorizing Cardiology Consultants of Texas to provide a copy, summary or narrative of my medical records (as indicated by the checkmark(s) below or otherwise release confidential information.

Complete records (a separate release is required for HIV test results, psychological / psychiatric information and drug / alcohol information).

Records of care from the following dates: _____ to _____

Records concerning the following condition(s): _____

Other (please specify) _____

Patient Full Name: _____

Patient Date of Birth: _____

Patient Social Security Number: _____ Phone: _____

RELEASE TO THE FOLLOWING PERSON (S):

Name / Hospital / Insurance Company/etc. _____

Address: _____

City: _____ State: _____ Zip: _____

Purpose(s) for release of information: _____

I understand that you will provide this information within 15 business days from receipt of this request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas State Board of Medical Examiners.

DATE RECEIVED

DATE COPIED/MAILED/FAXED

CCT EMPLOYEE NAME

PATIENT SIGNATURE OR REPRESENTATIVE SIGNATURE

DATE

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