Advanced Cardiovascular Care Center
9200 Pinecroft Suite 460, The Woodlands, Texas 77380
(281) 866-7701, (281) 866-7705 (fax)

Authorization for Release of Medical Records To:

By signing this form, I *_____ authorize **Advanced Cardiovascular Care Center** to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the **person(s) or entity** listed below.

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

_____

***Release my protected health information to the following person(s)/entity:**

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

The reasons or purposes for this release of information are as follows:

_____

_____

_____

Patient Signature [or parent, guardian or legal representative]:

*_____ **Date:** _____

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