Advanced Cardiovascular Care Center
9200 Pinecroft, Suite 460, The Woodlands, Texas 77380
837 FM 1960 Road West, Suite 101, Houston, Texas 77090
281-866-7701 Fax 281-866-7705

Authorization Form for Release of Protected Health Information

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Patient Name: _____

Contact Information: May we leave messages in your voice mail: □ Yes or □ No.

Below please list any family member or Physicians we may share your medical information with.
Release my protected health information to the following person(s)/entity:

Name: _____ Phone:_____
Street:_____ City: _____State:_____Zip:_____

Name: _____ Phone:_____
Street:_____ City: _____State:_____Zip:_____

Name: _____ Phone:_____
Street:_____ City: _____State:_____Zip:_____

This authorization shall be in force and effective until the following event and/or date: _____

_____

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

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Babu Varughese (Privacy Officer), 9200 Pinecroft, Suite 460, The Woodlands, Texas 77380 281-866-7701
I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Personal Representative_____Date:_____

Name of Patient or Personal Representative: _____Description of Personal Representative's Authority
By signing this form, I authorize you to use and disclose the protected health information described below

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

For office staff use only:
If the patient refuses to a written acknowledgement of the Notice of Privacy Practice, please indicate your comments:

_____

Name: _____ Date: _____