Rakesh Shah, MD ● BT Turakhia, MD ● Jinesh Shah, MD ● Francis Uricchio, MD
Salik Nazir, MD ● Andrew Badalamenti, MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: ____

Date of Birth: __________________

The above listed patient authorizes:

Bay Area Heart P.L.L.C
450 Blossom St. Ste. D, Webster, Texas 77598
Phone: 832-905-5940 ● Fax: 832-905-5941

Dates and Type of information to disclose:

- □ Complete Records
- □ All Office Notes
- □ All Hospital/Surgical Records
- □ All records from _____ to _____
- □ **Lab Reports**
  - □ most recent full report
  - □ all reports
- □ Diagnostic Images
- □ Drug/Alcohol Notes
- □ Psychotherapy Notes
- □ Other:

The purpose of the disclosure: □ Continuation of Care □ Referral □ Patients Request

Please send requested records to: ***(FEE MAY BE REQUIRED)***

Physician/Facility Name: ____

Address: ____

Phone: ______________________________ Fax: __________________________________

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Bay Area Heart PLLC. Unless revoked earlier this authorization will expire 180 days from the date of signing (6 months) or on the following date or event: __________________________________

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no-longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under applicable state of federal laws and regulations. I further understand that the person(s) I an authorizing to use or disclose my information may receive compensation for doing so.

____ ______________________
Signature of Patient/Legal Representative **Date**

____ ______________________
Printed name of Patient/Legal Representative **Relationship to patient**