



TEXAS INSTITUTE OF CARDIOLOGY, P.A.
FAISAL WAHID, M.D., F.A.C.C., F.S.C.A.I

4510 MEDICAL CENTER DR. SUITE 208
MCKINNEY, TEXAS 75092

Authorization to Release Health Care Information

Name: _____ Date of Birth: _____

Previous Name: _____ Social Security Number: _____

I request and authorize _____ to release health care information of the patient named above to:

Texas Institute of Cardiology

4510 Medical Center Drive, Suite 208
McKinney, TX 75069
214-544-7555
Fax: 214-544-7556

Copies of the complete history records in your possession concerning my illness and/or treatment to include:

EKGs

All Lab Work

All Cardiac Procedures

We will not disclose your Medical information for any purpose except for treatment, payment and healthcare operations. Any specific written authorization you provide may be revoked at any time by writing us. I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Patients Signature

Date

Print Name if Individual is not Patient

Relationship to Patient

Phone: 214-544-7555 / 866-391-4311

Fax: 214-544-7556

www.ticardiology.com

info@ticardiology