TEXAS INSTITUTE OF CARDIOLOGY, P.A.
FAISAL WAHID, M.D., F.A.C.C.,F.S.C.A.I
5313 West University Drive
McKinney, Texas 75071

Authorization to Release Health Care Information

Name: _____ Date of Birth: _____
Previous Name: _____ Social Security Number: _____

I request and authorize **Texas Institute of Cardiology, P.A.** to release health care information of the patient named above to:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

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

☐ EKGs ☐ All Lab Work ☐ All Cardiac Procedures

Purpose of Disclosure: ☐ Medical Center ☐ Employer ☐ Insurance ☐ Attorney

☐ Other: _____

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

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