Medical Release of Information Form

(Release from Harmony Heart Group)

Patient Name: _____ Date of Birth: _____

Phone # :_____ SS#: _____

I request and authorize:
Harmony Heart Group
11,700 Preston Rd, Suite 660, P.O. Box 147
Dallas, Tx 75230
Phone: 214-799-8991 Fax: 972-701-9803 email: info@harmonyheartgroup.com
To release the medical records of the above named patient to:

Name of Sender: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

This request and authorization applies to the following treatment condition or dates of treatment: (check one)

_____ All Health Care information **including** information related to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health or drug and or alcohol use.

_____ All Health Care information **excluding** the following:_____

_____

_____

I understand that I have the right to revoke this authorization by providing a written request to do so to the above named physician or organization. I understand that the revocation will not apply to information that has already by released.

_____

Signature of patient or authorized representative Date

Unless otherwise revoked, this authorization will expire 1 year from date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentially rules.