Cardiology Consultants of Houston, P.L.L.C.

Mark J. Schnee, M.D., F.A.C.C.
John O. Tyler, III, M.D., F.A.C.C.

Please Send My Records To:

Cardiology Consultants of Houston
6655 Travis Street, Suite 500
Houston, Texas 77030

RELEASE OF RECORDS AUTHORIZATION

TO HAVE RECORDS AVAILABLE AT THE TIME OF YOUR VISIT, PLEASE COMPLETE AU[illegible] POSSIBLE, TO THE PHYSICIAN OR FACILITY YOU WISH TO RELEASE YOUR RECORDS

Patient Name:	**Date of Birth:**
Address:	**Social Security #:**
City: State: Zip:	**Telephone #:**

I hereby authorize the release of my medical records from:

Physician:	**Telephone #:**
Address:	**Fax #:**
City: **State:** **Zip:**	

Release to: (Physician's Name) ❒ Mark Schnee, M.D. ❒ John Tyler, III, M.D.

I ❒ **do** ❒ **do not** (check applicable box) authorize this information to be faxed.	Fax #: **713.790.0591**
Name of person to receive information:	

REASON FOR RELEASE OF INFORMATION (check the appropriate box)

❒ **Medical Care** ❒ **Transfer of Medical Care** ❒ **Moving Out of Area** ❒ **Insurance**
❒ **Transfer of Care** ❒ **Specialist Consultation** ❒ **Personal File** ❒ _____

I understand that if I request copies of records for myself, or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

INFORMATION TO BE DISCLOSED (check the appropriate box)

❒ **Complete health records for the past 2 years** ❒ **History & Physical Exam** ❒ **Consultations**
❒ **Progress Notes** ❒ **Laboratory Tests** ❒ **Billing Records**
❒ **Other** _____

I understand this material may contain information relating to: Acquired Immunodeficiency Syndrome (AIDS) infection with HIV (Human Immunodeficiency Virus), Mental Health, Alcohol and/or Drug Abuse, Family History, Social History

REVOCATION: I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION FOR THE PURPOSES STATED ABOVE.

UNLESS OTHERWISE INDICATED, THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. THE PHYSICIAN AND EMPLOYEES ARE RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.

I understand there may be a fee for preparing and furnishing this information.

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**