LIVE OAK
CARDIOLOGY

AUTHORIZATION
FOR RELEASE OF INFORMATION

_____ _____
Patient Name **Date of Birth**

_____ _____
Address **Telephone Number**

I do hereby Authorize _____to disclose the above-named individual's health information

I authorize the release of... ☐ **All Records**

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to the following individual organization:

Live Oak Cardiology 155 Cimarron Park Loop Buda Texas/78610
Name (facility receiving information) Address **City** **State/Zip**

Phone: (512) 295-2558 Fax: (512) 295-2282
*****Phone/Fax Number*****

I understand that this authorization is voluntary and I may refuse to sign this release. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed and that information used of disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. Live Oak Cardiology may charge a processing fee for this service. This authorization will be in effect until _____(date or event). If no date given, release will remain active.

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at Live Oak Cardiology. If I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation

_____ _____
Signature of Patient or Patient's Representative **Date**

_____
Printed Name

_____
Relationship to Patient **OR**