HeartPlace®
The Future Of Cardiology Is Here

ARLINGTON SURGERY

Date of Request: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Attn: _____

_____

1. I hereby consent to the release and transfer of protected health information to:

Dr. James Norcross, Cardiothoracic Surgery
Dr. Baron Hamman, Cardiothoracic Surgery *(Satellite Office)*
902 West Randol Mill Road, Suite 200, Arlington, Texas 76012
Phone: 817-461-8327 Fax: 817-275-2525

The following information on (PLEASE PRINT):

Patient Name: _____ Date of Birth: _____ SS#: _____

Information being requested: _____

2. The above information is released for the history and care, possible involving surgical treatment, of the above named patient.

3. I understand that the specific information to be released may include, but is not limited to history, diagnoses, and/or treatment of drug and alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of this specific data. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. This authorization will expire ninety (90) days from the date of signature.

4. I authorize faxing the information to be disclosed to the requesting party _____ Yes _____No

5. I have read and understand this consent and I have signed it voluntarily and of my own free will.

_____	_____
Signature of Patient	Witness (Printed)
_____	_____
Specify Relationship to Patient	Witness Signature
_____	_____
Date of Patient Signature	Date of Witness Signature

Prohibition of Re-disclosure: This information has been disclosed to you from records that are confidential. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by law.