APEX
CARDIOLOGY OF HOUSTON

Authorization and Release of Medical Information

Patient Name:		Date of Birth:
Address:		Apt #:
City:	State:	Zip Code:
Phone:	Last 4 digits of Social Security #:	

Release of Information From:	Release of Information To:
Name:	**Apex Cardiology of Houston, PLLC**
Address:	11914 Astoria Blvd. Suite 410 Houston, TX 77089
City: State: Zip:	Phone #: (281) 922-9239
Phone:	**Fax #: (855) 518-5437**
Fax :	MD: ☐ Vu Hoang, M.D. ☐ Don Pham, M.D.

Purpose for Disclosure

☐ Continuing Care	☐ Consultation	☐ Transfer of Care	☐ Cardiac Clearance

Please release the following from date(s) of treatment from:	**(From):**	**(To):**

☐ History and Physicals	☐ Laboratory Reports	☐ EKG(s)
☐ Treadmill Reports	☐ Nuclear Stress Test Reports	☐ Operative Reports
☐ Echocardiogram	☐ Holter Reports	☐ Hospital Reports

☐ Other: (please specify)_____

I understand I have the right to revoke this authorization by providing a written request to do so to Apex Cardiology of Houston, PLLC. I understand that the revocation will not apply to information that has already been released and will take effect on the date that the request is received.

Unless otherwise revoked, this Authorization will expire twelve months from the date signed. I understand that authorizing the disclosure of this health information is voluntary.

I understand that Apex Cardiology of Houston, PLLC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Apex Cardiology of Houston, PLLC from all legal liability that may arise from this authorization.

By signing this form, I authorize Apex Cardiology of Houston, PLLC to request and use the PHI described above.

Signature of Patient:	**Date:**
Signature of Witness:	**Date:**