



**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:**

<b>Apex Cardiology of Houston, PLLC</b>		Name:		
11914 Astoria Blvd. Suite 410 Houston, TX 77089		Address:		
Phone #:	(281) 922-9239	City:	State:	Zip:
Fax #:	<b>(855) 518-5437</b>	Phone #:		
MD:	<input type="checkbox"/> Vu Hoang, M.D. <input type="checkbox"/> Don Pham, M.D.	Fax # :		

**Purpose for Disclosure**

<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Consultation	<input type="checkbox"/> Transfer of Care	<input type="checkbox"/> Other: _____
Please release the following from date(s) of treatment from:		<b>(From):</b>	<b>(To):</b>
<input type="checkbox"/> History and Physicals	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> EKG(s)	
<input type="checkbox"/> Treadmill Reports	<input type="checkbox"/> Nuclear Stress Test Reports	<input type="checkbox"/> Operative Reports	
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Holter Reports	<input type="checkbox"/> Hospital Reports	
<input type="checkbox"/> 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.

<b>Signature of Patient:</b>	<b>Date:</b>
<b>Signature of Witness:</b>	<b>Date:</b>