Heart of Texas Cardiology
2911 Medical Arts Street. Bldg. 10
Austin, Texas 78705
(512)474-5551

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (Please Print)

Patient Name: ____

Date of Birth: ____________________________ **SSN:** ____

Home Address: ____

Mailing Address: ____

Cell Phone #: _________________ **Home Phone #:** _________________ **Work Phone #:** _______________**Ext:** _____

Records Released FROM:

____
Physician or Clinic Name

____
Address

____
City, State, Zip

____
Phone Number

____
Fax Number

Records Released To:

David W. Hayes, M.D.

2911 Medical Arts Street. Bldg. 10

Austin, Texas 78705

Phone: (512)474.55.51

Fax: (512)474.73.24

Please release the following for date(s) of treatment from: ____

- ☐ History & Physical
- ☐ Treadmill Reports
- ☐ Echo
- ☐ Laboratory Reports
- ☐ Nuclear Report
- ☐ Holter Reports
- ☐ EKG (S)
- ☐ Hospital/Operative Reports(s)
- ☐ Other (please specify) _____________________

PURPOSE OR NEED FOR DISCLOSURE: ☐ Transfer of Care ☐ Continuation of Care

I hereby authorize the release of my medical records, including all results and test that my may include the following date: drug, alcohol and psychiatric treatment to party noted above. I understand that I may revoke this authorization at any time except to the extent that the action has been taken in reliance on it. This authorization will expire in one year from the date of my signature or as otherwise specified by date or events of conditions as follow: ____________________________________.

____ _____________________________
Signature of Patient Date

____ _____________________________
Signature of Witness Date