Patient Name: ______________________________ Date: ______________

DOB: ____/____/____ Age: _____

AUTHORIZATION TO RELEASE INFORMATION ABOUT PATIENTS CONDITION/TREATMENT

In accordance with the Medical Privacy Act of Texas, Physicians and/or staff of EP HEART, are unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release and/or obtain information regarding your care to someone other than yourself, please complete the following authorization.

I hereby authorize Physicians and/or staff of EP HEART, to release information pertaining to my condition and/or care to only spouse or those family members, physicians and/or others involved in my care as listed below:

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

____

Patient Signature

____

Date

If not signed by patient, please indicate relationship: ______________________________