Cathy Hart Family Medicine
Southwood Tower
19221 I-45 South, Suite 400
Shenandoah, TX 77385
832-585-0095 Phone
832-585-0088 Fax

Authorization for Release of Information ***To Us***

I, the undersigned hereby authorized:_____
_____
_____
_____

To release the information specified below to the physician marked above.

The reason for this release of information is ( ) **continuity of care** or
( ) other_____

I understand that my records are confidential and cannot be disclosed without written authorization, except as otherwise provided by law.

This authorization is valid for 6 months and may be revoked by the patient, orally or in writing at anytime prior to six months.

Information to be released should include all history, physical exam and progress notes, lab and X-Ray reports, and all correspondence relating to my medical care unless otherwise specified below. Your prompt attention is greatly appreciated.

_____
Patient Signature

_____
Patient Name (printed)

_____
Date of Birth

_____
Date

According to state/Federal Law, the following must be signed in order to process all records requests, if such information exists in your chart.

_____ Mental Health Records

_____ Alcohol/substance Abuse Records

_____ HIV Records