Heart Point

Muhammad Chaudhry, M.D.
945 Stockton Drive, Suite 7140
Allen, Texas, 75013
Office: 214-977-6366 / 214-547-0650
Fax: 214-977-6329 / 214-547-0658

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____ Phone #: _____

I authorize records: (Please select one):

☐ To be release **TO** Heart Point From:

Facility: _____

Phone #: _____ Fax #: _____

☐ To be release **FROM** Heart Point To:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Email: _____

Information to be released: (Check all that apply)

	ALL Medical Records		Radiology Reports		Visit & Encounters
	Laboratory Reports		Consultation Reports		Emergency Room Records
	Procedure Reports		EKG Reports		Medication / Prescription List
Other:					

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information to be released may include but not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV/AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

This authorization will expire 180 days from the date of my signature unless I revoke the authorization prior to that time. Please allow 48-72 hours for the records to be release as per our HEART POINT policy.

Printed Name: _____

Signature: _____

Date: _____