HALL-GARCIA CARDIOLOGY ASSOCIATES

PATIENT AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

This notice describes how information about your health may be used and disclosed and how you can get access to this information. Please review it carefully.

We may use and disclose protected health information about you only with your authorization. Specific information may include but is not limited to name of your insurance plan and your insurance identification number (including policy and group number), the insured's name, address, phone number, gender, and date of birth; your name, date of birth, address, phone number, and gender; dates of service for and types of surgeries, hospitalizations, and treatments; and diagnosis and procedure information.

Name of persons using and /or disclosing: Hall-Garcia Cardiology Associates (HGCA)

The purpose of the requested us and/or disclosure is treatment, payment, or health care operations. By signing this form, you consent to our using and/or disclosing your protected health information as specified in this authorization. You may revoke this authorization, in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward written revocation referencing this authorization to our Chief Privacy Officer, Ms. Mary Murphy, at:

Hall-Garcia Cardiology Associates

6624 Fannin St., Suite 2480

Houston, TX 77030

Patient Name: ____ **Date of Birth:** _______________

You may refuse to sign this authorization. We will not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on your providing this authorization (subject exceptions). You may inspect a copy of protected health information in accordance with our Notice of Privacy Practices. We will provide a copy of this signed authorization to you.

Signed: ____ **Date:** _______________________

Print Name: ____

I authorize Hall-Garcia Cardiology Associates to leave necessary messages at my home or place of employment.

Signed: ____ **Date:** _______________________

I authorize Hall-Garcia Cardiology Associates to speak to the following persons regarding my medical condition, lab results, and any other personal health information.

Name: ______________________________________ **Relationship to Patient** ___________________

Name: ______________________________________ **Relationship to Patient** ___________________

Signed: ____ **Date:** _______________________