AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **Heart Rhythm Specialists, PLLC** to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus, as well as behavioral and mental health (excluding psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other related information. I fully understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, the released information may no longer be protected by federal and state privacy regulations.

____

Print Patient Name Date of Birth

Date of Service (if known): ____

Description of information to be released, check all that apply.

____ Hospital Records ____ Holter Reports ____ Non HRS Physician Records
____ History & Physicals ____ Device Reports ____ Cardiac Monitoring Reports
____ Non-Invasive Testing ____ Billing Records ____ Registration Records
____ Nuclear Testing ____ Laboratory Reports Other __________________________

Description of the purpose of the use and / or disclosure:

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The health information described herein shall be released to:

____ Hospital ____ Physician ____ Insurance Company ____ Attorney ____ Patient ____ Other

____

Name Address City, State, Zip

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until ________________________.

I understand that I may revoke this authorization at any time by notify Heart Rhythm Specialists, PLLC in writing at **4500 Hillcrest Road, Ste. 100, Frisco, TX 75035**. I also understand that the written revocation must be signed and dated with a date that is later that the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

____ __________________________

Signature of Patient or Patient's Representative Date

____

Printed Name of Patient's Representative

______________________________ or _______________________________________

Relationship to Patient or Legal Authority, attach supporting documentation