LONE STAR
Cardiovascular Institute

TRANSFER OF CARE RELEASE OF PROTECTED HEALTH INFORMATION

Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out on each patient **annually**. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization outlined below.

Patient Name:	DOB:
Full Address:	Phone:

I authorize _____ to disclose my protected health information for continuance of care under the supervision of the entity outlined below.

Person/Organization Name:	
Address:	Phone #:
City, State, Zip:	Fax #:

Person/Organization Name:	
Address:	Phone #:
City, State, Zip:	Fax #:

Information Authorized to Disclose:

☐ All health information ☐ History/Physical Exam ☐ Past/Present Medications ☐ Lab Results
☐ Physician's Orders ☐ Patient Allergies ☐ Operation Reports ☐ Consultation Reports
☐ Progress Notes ☐ Discharge Summary ☐ Diagnostic Test Reports ☐ EKG/Cardiology Reports
☐ Pathology Reports ☐ Billing Information ☐ Radiology Reports & Images ☐ Other_____

Initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes) _____ HIV/AIDS Test Results/Treatment
_____ Genetic Information (including Genetic Test Results) _____ Drug, Alcohol, or Substance Abuse Records

Date: _____

Patient: _____
Signature of patient or responsible party

_____
Printed name of patient or responsible party (relationship if not self)