Today's Date: ______________

# Houston Arrhythmia Associates, P.A.

**Sohail Jalal, M.D.    Alexander Drtil, M.D.**

## Authorization for Disclosure Inspection Amendment of Protected Health Information

| Patient Name: | | Date of Birth: | |
|---|---|---|---|
| Social Security #: | | Telephone #: | |

| I hereby authorize ____________________________________________(facility releasing information) to release information from the medical records of PATIENT NAMED ABOVE to: | | | |
|---|---|---|---|
| Physician/Facility: | | Address: | |
| Phone #: | | Fax #: | |
| For Treatment Dates: | | For the following purposes: | ■ Medical Care<br>■ Legal<br>■ Insurance<br>■ Other, details: |

**Selected Portions:**

| Abstract/Pertinent Information: Entire Record EXCLUDING: | | Nursing Notes: Entire Record EXCLUDING: | |
|---|---|---|---|
| Lab: Entire Record EXCLUDING: | | H&P: Entire Record EXCLUDING: | |

- ■ MD Progress Notes
- ■ Operative/Procedure Report
- ■ MD Orders
- ■ EKGs
- ■ Itemized Bill
- ■ Face Sheet
- ■ Other, details:

__________________________________

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only the treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff at Houston Arrhythmia Associates to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time exempt to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above-named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

**Patient/Parent/Guardian Signature:** ______________________________________________

**Patient/Parent/Guardian Name:** ________________________________________________

**Date:** ______________________

Fees/charges will comply with all laws and a regulation applicable to release of Protected Health Information Payment is due at time of release.