



CIVA
THE CARDIOVASCULAR SPECIALISTS

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize:

Name of your doctor or hospital

Address

City

State

Zip

Phone

to release the following specified information relative to the (date) _____
hospitalization and/or treatment of:

NAME OF PATIENT: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

DAYTIME TELEPHONE NUMBER: _____

RELEASE INFORMATION TO: _____
(CIVA Physician)

CIVA, 7150 Greenville Ave., Suite 500, Dallas, TX 75231 214.369.3613 FAX: 214.369.6042

FOR THE PURPOSE OF: _____

SPECIFIC RECORDS TO BE RELEASED: _____

I understand that my records are protected by Texas law and federal regulations. I understand that the specific information to be disclosed may include history of drug and alcohol abuse, or mental health treatment or treatment of Acquired Immune Deficiency Syndrome (AIDS). I further understand that this consent is subject to revocation at any time in the form of written notice from me, except to the extent that action has been taken in reliance hereon, or without revocation, will expire 120 days from the date of the signature below.

Signature of Patient

Date

Signature of Parent/Guardian (If Required)

Date

Signature of Witness

Date