# Heart Center For Children

PATIENT AUTHORIZATION for MEDICAL RELEASE
of PROTECTED HEALTH INFORMATION

I authorize HEART CENTER for CHILDREN
7777 Forest Lane, Suite B320
Dallas TX 75230
to release information about me / my child

Patient Name: _____

Date of Birth: _____

Address: _____
Streeet Address City ST Zip

This authorization is in effect for 1 (one) year from this date: _____ / _____ / _____
MM DD YEAR

Purpose of Disclosure: ___Medical Care ___Insurance ___Attorney ___Other

This information is to be released to:

Name of Doctor / Facility: _____

Address of Doctor / Facility: _____

Phone Number of Doctor / Facility: ( _____ ) _____ - _____

FAX Number of Doctor / Facility: ( _____ ) _____ - _____

I agree that a photocopy / fax copy of this authorization may be considered valid YES / NO

Patient / Parent / Guardian Signature: _____

Date: _____ / _____ / _____ Phone Number: ( _____ ) _____ - _____
MM DD YEAR

7777 Forest Lane • Suite B-320 • Dallas, Texas 75230-6820
Phone (972) 566-4299 • Fax (972) 566-4210
*Satellite Offices*:
Frisco • Grapevine • Kaufman • Las Colinas • Lewisville • Nacogdoches • Plano • Rockwall • Waxahachie