THE HEARD CLINIC

FERTILITY / GYNECOLOGY / ENDOCRINOLOGY

Advanced Reproductive Medicine

AUTHORIZATION TO RELEASE/OBTAIN HEALTH CARE INFORMATION

Patient Name: _____ **DOB:** _____

SSN: _____ **Previous Name:** _____

□ Authorization to release my medical records to me
□ Authorization to send my medical records to Dr. Heard
1315 St. Joseph Pkwy, Houston, TX 77002, Suite 1305
Phone: 713) 878-0878 Fax: 713) 654-8795
□ Authorization for Dr. Heard to send my medical records to:

Doctor: _____ **Phone Number:** _____

Address: _____

□ Health care information relating to the following treatment, condition or dates of treatment

_____

□ All health care information

□ Other: _____

Reason you are requesting Medical Records to be sent: _____

_____ Transferring Care to another Doctor

_____ Second Opinion _____ Pregnant and Need an OB

_____ Moving _____ Price/Not on my insurance plan _____ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I understand that I may revoke this consent for release for medical records at any time except to the extent that action has been taken in reference to it. If you chose to revoke consent, it must be done in writing. **I also understand that a fee for preparing and furnishing this information will be charged according to rulings set forth by the Texas State Board of Medical Examiners.**

Signature: _____ Date: _____
(Signature of patient or patient's authorized representative)
Print Name: _____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)
Authorization to FAX: □ Yes □ No