

**EXCEL CARDIAC CARE**

Phone: (817) 518-9005  
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Fax: (817) 518-9015

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

This is a release form for authorization of medical information to be transferred between health care providers, health insurance companies and any other party involved in my medical care.

Patient Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize the following facilities/hospitals and doctor(s) to release all medical information to Excel Cardiac Care to better manage my health.

This request includes hospital summaries, echocardiogram reports, cardiac catheterization reports, vascular reports, laboratory reports, electrocardiograms, physician progress notes, and any other healthcare information relating to my health condition.

List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Legal Guardian Signature

\_\_\_\_\_  
Relation of Legal Guardian