Round Rock Cardiology, P.A.
Thomas C. Vinson, M.D.
16010 Park Valley Dr. Ste 200
Round Rock, TX 78681
p) 512-244-9944 / f) 512-244-9977

Authorization for Release of Medical Information

Please note there may be a charge for providing copies of your medical records as allowed by Federal & State Law

I authorize Dr.Thomas Vinson M.D. to obtain information from:	I authorize Dr.Thomas Vinson M.D. to release information to:
Name of Provider or Facility	Name of Provider or Facility
_____	_____
Fax#	Fax#
_____	_____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold Dr. Thomas Vinson liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship of Patient (if Legal Representative) Witness

TYPE OF RECORDS REQUESTED:

- Progress notes
- Any lab/pathology results
- Any radiology results
- Latest hospital, discharge summary, and office visit notes
- Medication list

Specific records as follows: _____

By signing this document, you are approving Round Rock Cardiology to obtain & release your medical records as outlined above.

Patient Name (print) _____ Date of Birth_____

Patient Signature _____Date Signed_____