

Round Rock Cardiology, P.A.

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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: Name of Provider or Facility _____ Fax# _____	I authorize Dr. Thomas Vinson M.D. to release information to: Name of Provider or Facility _____ 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 _____ Relationship of Patient (if Legal Representative)		_____ Date _____ 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 _____

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