Patient Information

Patient Name_____
Address_____
City_____ **State**_____ **Zip**_____ **Sex**_____ **Age** _____
Home Phone_____ **Cell Phone**_____
SSN _____ **Birth date** _____ **Marital Status: S M W D**
Driver's License _____ **State Issued** _____
Referring Physician_____
Primary Care Physician (PCP)_____
Email Address_____

Patient Employer _____ **Work #** _____
Address _____ **Occupation**_____
City _____ **State** _____ **Zip** _____

Spouse Name _____ **SSN** _____ **Birthdate** _____
Employer _____ **Work Phone**_____
Nearest Relative _____ **Relationship** _____ **Phone No.**_____

Insurance Information

Cardholder Name _____ **SSN** _____ **Birthdate** _____
Primary Insurance _____ **Phone #** _____
Address _____ **City** _____ **State** _____ **Zip** _____
ID No. _____ **Group No.** _____ **Insured** _____

Cardholder Name _____ **SSN** _____ **Birthdate** _____
Secondary Insurance _____ **Phone #** _____
Address _____ **City** _____ **State** _____ **Zip** _____
ID No. _____ **Group No.** _____ **Insured** _____

I hereby authorize Cypress Cardiology P.A. to furnish information to insurance carriers concerning my illness and treatments and hereby assign all insurance benefits payable for services rendered to my dependents or myself.

Signature_____ **Date** _____

Authorization to Obtain or Release of Medical Records From Medical Providers

I authorize **Cypress Cardiology, P.A.** ("the Practice") to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid, and any insurance company, third party administrator or managed Care Company.

X_____ _____

Patient Signature *Date*

_____ _____

Printed Name *Date of Birth*

Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of the Practice to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization die to the severity of your medical condition, the law stipulates that these rules may be waived.

_____I do not authorize the Practice to release any or all information concerning my medical care or finances to any individual except as set forth above.

_____I authorize the Practice to verbally release any or all information concerning my medical care or finances to the following individuals:

_____ _____ _____

Name *Relationship to Patient* *Contact Phone #*

_____ _____ _____

Name *Relationship to Patient* *Contact Phone #*

X_____ _____

Patient Signature *Date*

_____ _____

Witness *Date*

Medical Records Release Form

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below or otherwise release confidential information.

Patient Name: _____

Date of Birth: _____

Social Security #: _____

___ Complete Record

___ Records of care from the following dates: _____ to _____

___ Records concerning the following conditions: _____

___ Other, please specify: _____

___ Confer with person(s) listed below orally about my medical information

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

Release to the following person(s):

Name: Cypress Cardiology, P.A.
Thomas L. DeBauche, MD, FACC
Peter Razeghi, MD, FACC

Address: 21212 Northwest Freeway, Suite 405
Cypress, Texas 77429

Phone: (281) 890-8588 **Fax:** (281) 894-0426

The reason or purpose for this release of information is as follows:

_____

_____

Patient Signature: _____ **Date:** _____

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas State Board of Medical Examiners.