HIPAA Privacy Authorization Form

Patient Name: _____ Date of Birth: _____

For the purpose of continuity of care, I request and authorize

_____ (another healthcare provider or hospital)

to use and disclose the protected healthcare information of the patient named above to:

Younis Cardiology Associates, PLLC

6560 Fannin St., Suite 1750

Houston, TX 77030

Phone 713-790-0400. Fax 713-799-2121

This request and authorization applies to:

□ All healthcare information

□ Only healthcare information relating to the following treatment, condition, or dates:

_____ _____

Patient's Signature Date Signed