Patel Cardiovascular Consultants LLC

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RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE MY MEDICAL RECORDS TO PATEL CARDIOVASCULAR CONSULTANTS LLC. AT THE ADDRESS/FAX NUMBER LISTED ABOVE.

PATIENT:_____DOB:_____

SIGNATURE: _____DATE:_____

WITNESS:_____DATE:_____

I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE MY MEDICAL RECORDS FROM:

DOCTOR/FACILITY:_____

ADDRESS:_____

PHONE:_____FAX:_____

O	PROGRESS NOTE	O	DUPLEX STUDIES
O	MEDICATION LIST	O	CARDIOVASCULAR STRESS TEST
O	PACER/ICD INTERROGATION	O	ECHO REPORTS
O	EKG	O	NUCLEAR SCAN/MUGA
O	LIPID PANELS/BLOOD WORK	O	ULTRASOUND REPORTS
O	VISIT NOTES/PROGRESS NOTES	O	OTHER HELPFUL REPORTS