AUTHORIZATION FOR MEDICAL RECORD RELEASE

REQUESTING FOR:

Patient Name: ______________________________

Date of Birth: ______________________________

This is a written request that I hereby authorized **ANSAARIE CARDIAC AND ENDOVASCULAR CENTER OF EXCELLENCE** to request release of my medical records. This authorization is valid of 6 months from the date of my signature unless revoked by me or my authorized agent.

REQUESTING FROM:

Company/Physician: ______________________________

Phone: ______________________________

Fax Number: ______________________________

- ☐ Recent Office Visit Notes/ H&P
- ☐ Ultrasound Results (Echo, Carotid, Renal, Abdominal, Arterial,etc)
- ☐ Nuclear Testing (Stress Test)
- ☐ Procedure (Ablation, CABG, Cath, TEE, Angioplasty/Stent)
- ☐ Hospital Records (Discharge/ER Report)
- ☐ Laboratory Results/EKG
- ☐ Radiology Results (Xray, CT, MRI, etc)
- ☐ ALL OTHER AVAILABLE RECORDS

PATIENT'S SIGNATURE ______________________________ **DATE** __________

215 Hwy 17 S., East Palatka, FL 32131

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