CARDIOVASCULAR SPECIALISTS
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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____Date of birth:_____

The information you may release subject to this signed release for is a follows:

__Complete Records	__History & Physical	__Progress Notes
__Care Plan	__Lab Reports	__Radiology Reports
__Pathology	__Treatment Record	__Operative Reports
__Hopital Reports	__Medication Report	__Echocardiogram
__Stress Test	__EKG	__Heart Cath

__Other _____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____
Address:_____
Phone:_____ **Fax:** _____

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

Signature:

_____ _____
Patient Name Signature of Patient or Personal Representative

_____ _____
Patient Date of Birth or Social Security Number Printed Name of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority