

2210 61st St W, Bradenton, FL 34209

Phone: (941) 747-8789 Fax: (941) 747-8711

## MEDICAL RECORDS RELEASE

Name: SSN Address:			Date of Birth://
		Phone #:	
CardioVascular Solutions ma	y <u>OBTAIN</u> copies of my med	ical records	listed below from:
1.(Physician or facility which has health information) Name: Address:		Name:	ian or facility which has health information)
Phone: Fax:		Phone:	Fax:
CardioVascular Solutions ma	y <u>RELEASE</u> copies of my rec	cords listed k	pelow from:
1.(Physician or facility which has health information) Name: Address:		Name:	ian or facility which has health information)
Phone: Fa	x:	Phone:	Fax:
Consultation (date)	Event Recorder (date)		Holter (date)
Progress Note (date)	Hospital Records (date)		Cath/PCI (date)
Stress Echo (date)	Echocardiogram (date)		EKG (date)
Nuclear Stress (date)	Lab Reports (date)		Copy ALL Records (up to 7 years)
Other			
CONTAIN CONFIDENTIAL IN PHYSICAL ABUSE OR DRUG	NFORMATION RELATING TO	) PSYCHIAT	RE THAT THE RECORDS RELEASED MAY RIC OR PSYCHOLOGICAL TESTING,
Patient's Signature	Date		Signature of Witness
*If individual is unable to sign	this authorization, please comp	lete the infor	mation below:
Name of Guardian/Representat	ive Legal Relation	nshin	Date

THIS AUTHORIZATION EXPIRES THREE YEARS AFTER DATE SIGNED THE INFORMATION CONTAINED HEREIN IS PROHIBITED FOR USE OTHER THAN THE STATED PURPOSE Updated 11/2022