LOURDES | Cardiology Services

ASSOCIATED cardiovascular CONSULTANTS LOURDES

Records Release Authorization

Name (please print): _____Date of Birth:_____

Street Address: _____

City, State/Zip:_____

Signature:_____ Date:_____

Witness:_____Date:_____

<u>For Office Use Only:</u>

I hereby authorize and request you to release to: _____

_____

The complete medical records in your procession concerning my illness and/or treatment during the period from:_____to: _____

Including copies of the electrocardiogram, x-ray, laboratory reports as well as any other significant reports:

__Lab work done within the last year

__Stress test results

__Echo or Carotid results

__Discharge summary or operative report

__Catheterization/EP Study

__Medication List

__Chest X- Ray

__ EKG

__Holter Report

__Other_____

Please fax the above records to _____