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RECORDS RELEASE REQUEST

To:

I, _____, hereby request that you release my MEDICAL RECORDS to:

CENTRAL FLORIDA CARDIOVASCULAR CONSULTANTS, P.L.
915 Harley Strickland Blvd
Orange City, FL 32763
Phone: (386) 456-0300
Fax: (386) 456-0303

This includes a report of my diagnosis, treatment, prognosis and recommendations, as well as any other data pertinent to your treatment of me. I request ALL of my records to be sent unless specific dates or specific tests are listed below. Thank you.

- Release records only for the following period.

FROM: _____ / _____ / _____ TO: _____ / _____ / _____

- Release records only for the following test(s) / report(s):

All cardiology records including ekg's, stress tests, echocardiograms, carotid ultrasounds, holter monitors or event monitors, arterial segmental_ pressures, and etc. Related to cardiology.

REASON FOR REQUEST:

___ Continuity of Care ___ Treatment ___ At the Request of Individual ___ Please Include All Sensitive Information

Date of Request

Date of Birth

Social Security Number

Patient's Telephone Number

Patient Printed Name

I understand and give my permission for my records to be sent via facsimile (fax machine).

Patients Signature: _____

Faxed: _____ / _____ / _____