Florida
Cardiopulmonary Center
Central Florida Cardiovascular Consultants, PL

Ratan K. Ahuja, M.D, F.A.C.C, F.S.C.A.I
Diplomat ABIM in Cardiovascular Diseases & Interventional Cardiology
Assistant Professor, UCF College of Medicine

Sameer Chadha, M.D.
Diplomat ABIM in Cardiovascular Diseases

Natasha H. Tulshi, MSN, ARNP

RECORDS RELEASE REQUEST

To:

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

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

CENTRAL FLORIDA CARDIOVASCULAR CONSULTANTS, P.L.
759 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:_____/_____/_____