Florida Cardiopulmonary Center
Central Florida Cardiovascular Consultants, PL

Florida Amputation Prevention Institute

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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:_____/_____/ _____