Medical Records Request

Patient: _____ **DOB:** _____ **SS#:**_____

To: _____ **Fax #:** _____

The release of any information considered confidential under Florida Law, such as that regarding psychiatric, drug or alcohol abuse, HIV/AIDS testing, counseling, or treatment, or other sensitive materials which may or may not be in my medical records is:

___AUTHORIZE OR ____UNAUTHORIZE

This written request for release of medical records is valid for 12 months from the date of my signature unless revoked in writing by me or my authorized agent. I agree to hold both the sending and receiving parties to this request harmless from any and all costs, liability and damages of any nature resulting or indirectly from the release of my medical records.

TESTS OR OPERATIVE REPORTS / FILMS

- ☐ **ALL MY MEDICAL RECORDS**
- ☐ LAST OFFICE VISIT NOTES / H & P/ Consult
- ☐ DISCHARGE SUMMARY _____Date
- ☐ ECHO DOPPLER Results
- ☐ STRESS TEST (NUCLEAR/TREADMILL)
- ☐ PET SCAN Report(s)_____
- ☐ EKG tracing(s) _____ Date_____
- ☐ HOLTER results only
- ☐ EVENT Monitor Tracings
- ☐ ABPM report(s)_____ Date
- ☐ CAROTID US Doppler Report(s)
- ☐ RENAL/Mesenteric US Doppler(s)
- ☐ ARTERIAL DOPPLER (U/L)
- ☐ Last PPM or AICD Check report
- ☐ MRI / MRA/ MRV Report(s) _____Date
- ☐ FCCI Cath Lab Procedure(s) Reports
- ☐ Sleep Study_____
- ☐ CPAP titration _____
- ☐ PACER/AICD IMPLANT report(s)
- ☐ EP Ablations or Study report(s)_____ Date
- ☐ CATH & OR Intervention(s) reports
- ☐ ANGIOGRAM or Intervention (s) (RENAL)
- ☐ CABG, Valve Surgery Reports __Date_____
- ☐ Ashchi Vascular & Heart Cath Lab Procedure(s) Reports
- ☐ CARDIAC ANGIOPLASTY/STENT
- ☐ CARDIAC ANGIOPLASTY/STENT
- ☐ Cardioversion W / W/O TEE Report (s)
- ☐ TEE Report(s) ____ TEE CD_____
- ☐ VEIN ABLATION /Procedures
- ☐ Labs, Blood Work _____ Date(s)
- ☐ CT Scan __CD or __Thumb Drive (Film)__
- ☐ CT scan report of_____ Date_____
- ☐ CT SCANS AAA _____ Report_____
- ☐ FCH&V Cath Lab Procedure(s) Reports
- ☐ Doctor Notes_____
- ☐ Tilt table

_____ _____ _____

PATIENT'S SIGNATURE DATE WITNESS

3900 University Blvd S. Jacksonville, FL 32216
Main (904) 222-6656 • Fax (904) 222-6657
www.DrAshchiHeart.com