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DrAshchiHeart.com

MEDICAL RECORDS REQUEST

Patient: _____ DOB: _____ SSN: _____

To: _____ Fax Number: _____

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:

AUTHORIZED OR UNAUTHORIZED

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.

Type of Medical Information Requested for Continuity of Care

- | | |
|--|---|
| <input type="radio"/> All Medical Records | <input type="radio"/> Tee Report |
| <input type="radio"/> Laboratory Results | <input type="radio"/> Diagnostic Imaging, CT's/ MRI's |
| <input type="radio"/> EKG Tracings | <input type="radio"/> EP/Vein Ablation |
| <input type="radio"/> All Cardiac and Vascular Testing | <input type="radio"/> Pacer/AICD Implant |
| <input type="radio"/> Cath Report | <input type="radio"/> Holter/ Zio Patch/ CAM |
| <input type="radio"/> CABG, Valve Surgery Report | <input type="radio"/> Other: _____ |

PATIENT'S SIGNATURE

DATE

PRINTED NAME OF PATIENT

WITNESS