Release of Medical Records

PATIENT NAME: _____ **DOB:** _____

RELEASE OF MEDICAL RECORDS TO CHILDREN'S CARDIOLOGY CLINIC by:

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

Please include any cardiology clinic notes, echocardiogram reports, ECG's, cardiac monitor results, genetic test results and EP or Cath lab reports for _____ to _____.

Please fax records to 888-494-2369. Call the office at 407-588-0550 if any questions.

RELEASE OF MEDICAL RECORDS FROM CHILDREN'S CARDIOLOGY CLINIC to:

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

I consent to allow my protected health information to be released as noted above. I understand that this authorization will expire one year from the date it is signed unless I specify otherwise.

Patient/Guardian Signature _____

Full Name of Guardian _____

Date _____