

CARDIOVASCULAR MEDICAL ASSOCIATES

Cardiovascular Disease- Internal Medicine

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REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT IDENTIFICATION:

PRINTED NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE #: _____

INFORMATION TO BE RELEASED:

DISCHARGE SUMMARY

PROGRESS NOTES

LAB RESULTS

COMPLETE RECORD

VIDEO/CD

CONSULTATION NOTES

X-RAY RPTS

OTHER _____

WHO AND WHERE TO SEND/RELEASE INFORMATION:

NAME: _____

ADDRESS: _____

Signature _____ Date _____