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

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PATIENT'S SIGNATURE DATE WITNESS

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