

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

- | | |
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| <ul style="list-style-type: none"><input type="checkbox"/> ALL MY MEDICAL RECORDS<input type="checkbox"/> LAST OFFICE VISIT NOTES / H & P/ Consult<input type="checkbox"/> DISCHARGE SUMMARY _____Date<input type="checkbox"/> ECHO DOPPLER Results<input type="checkbox"/> STRESS TEST (NUCLEAR/TREADMILL)<input type="checkbox"/> PET SCAN Report(s)_____<input type="checkbox"/> EKG tracing(s) _____ Date_____<input type="checkbox"/> HOLTER results only<input type="checkbox"/> EVENT Monitor Tracings<input type="checkbox"/> ABPM report(s)_____ Date<input type="checkbox"/> CAROTID US Doppler Report(s)<input type="checkbox"/> RENAL/Mesenteric US Doppler(s)<input type="checkbox"/> ARTERIAL DOPPLER (U/L)<input type="checkbox"/> Last PPM or AICD Check report<input type="checkbox"/> MRI / MRA/ MRV Report(s) _____Date<input type="checkbox"/> FCCI Cath Lab Procedure(s) Reports<input type="checkbox"/> Sleep Study_____<input type="checkbox"/> CPAP titration _____ | <ul style="list-style-type: none"><input type="checkbox"/> PACER/AICD IMPLANT report(s)<input type="checkbox"/> EP Ablations or Study report(s)_____ Date<input type="checkbox"/> CATH & OR Intervention(s) reports<input type="checkbox"/> ANGIOGRAM or Intervention (s) (RENAL)<input type="checkbox"/> CABG, Valve Surgery Reports __Date_____<input type="checkbox"/> Ashchi Vascular & Heart Cath Lab Procedure(s) Reports<input type="checkbox"/> CARDIAC ANGIOPLASTY/STENT<input type="checkbox"/> CARDIAC ANGIOPLASTY/STENT<input type="checkbox"/> Cardioversion W / W/O TEE Report (s)<input type="checkbox"/> TEE Report(s) _____ TEE CD_____<input type="checkbox"/> VEIN ABLATION /Procedures<input type="checkbox"/> Labs, Blood Work _____ Date(s)<input type="checkbox"/> CT Scan __CD or __Thumb Drive (Film)___<input type="checkbox"/> CT scan report of _____ Date_____<input type="checkbox"/> CT SCANS AAA _____ Report_____<input type="checkbox"/> FCH&V Cath Lab Procedure(s) Reports<input type="checkbox"/> Doctor Notes_____<input type="checkbox"/> Tilt table |
|---|--|

PATIENT'S SIGNATURE

DATE

WITNESS

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