Records Release Authorization

To:_____

I,_____
(Please print name, date of birth and social security number)

I hereby request my records to be released to:

Palm Beach Cardiology Center
3365 Burns Road, Suite 101
Palm Beach Gardens, Florida 33410
Phone: (561) 775-1061 Fax: (561) 775-1064

This is to include my diagnosis, treatment, prognosis and recommendations as well as other information to your treatment of me.

Signature: _____ Witness: _____

Address: _____ Date: _____

_____

Date of treatment: _____

( ) EKG ( ) Progress notes ( ) Ultrasound of _____ ( ) Stress test

( ) Lab work ( ) Chest X Ray ( ) Echo doppler ( ) Hospital
To include: H & P, Consults, Emergency record, Operative reports, Discharge summary

Other:_____