

**Please list any cardiologists you have seen in the past, check any of the following tests you have had in the last two years, then complete and sign the records release.**

Cardiologists: \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> EKG                                 | <input type="checkbox"/> GI Series / Endoscopy   |
| <input type="checkbox"/> Echocardiogram                      | <input type="checkbox"/> Cardiac Catheterization |
| <input type="checkbox"/> Stress test of any kind             | <input type="checkbox"/> Other Angiograms        |
| <input type="checkbox"/> 24 hour holer monitor (with strips) | <input type="checkbox"/> Chest X-Ray             |
| <input type="checkbox"/> 30 day monitor (with strips)        | <input type="checkbox"/> Gallbladder Sonogram    |
| <input type="checkbox"/> Lab                                 | <input type="checkbox"/> Pulmonary Function Test |

Hospitalized Where: \_\_\_\_\_  
\_\_\_\_\_

**REQUEST FOR RELEASE OF MEDICAL RECORDS**

Current Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I hereby request that my medical records be released to:**

Physician's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature