



HEART SCIENCES CENTER

AUTHORIZATION TO RELEASE/RECEIVE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
Release/Receive healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

We are hereby authorized to receive any medical notes, reports, labs, operative reports and films.

Yes No I authorize the release of any echocardiogram, stress test, cta and angiogram films available.

Phone Number: _____ Fax Number: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.