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Phone: 480-782-0101 Fax: 480-782-1251

MEDICAL RECORDS RELEASE FORM

I, ____ hereby request that
(PLEASE PRINT PATIENT NAME)

____, release the
(NAME OF FACILITY WHERE RECORDS ARE BEING REQUESTED)

following records to **CHANDLER CARDIOLOGY ASSOCIATES**.

Phone: ____________________________ Fax: __________________________

Patient SSN: ________________________ Patient DOB: ___________________

- ☐ Radiology
- ☐ Consult notes
- ☐ Hospital progress notes (including admission and discharge summaries)
- ☐ Emergency Department reports
- ☐ Cardiac testing (Including Cardiac Cath, CABG, TEE, Stress test, and Ultrasounds)
- ☐ Vascular reports (Including arterial and venous ultrasounds)

Other: ____

Date(s) of service: ____

X____ DATE: __________________
SIGNATURE OF PATIENT

X_________________________ ____________________ DATE: __________________
SIGNATURE OF RESPONSIBLE PARTY **PRINTED NAME**