Ahtisham Shakoor M.D., FACC
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AUTHORIZATION FOR RELEASE OF INFORMATION

NAME OF PATIENT: ________________________________ DOB: ________/________/________

DATE(S) OF SERVICE: ____

PURPOSE FOR RELEASE: ____

PLEASE RELEASE THE FOLLOWING INFORMATION:

- ☐ OFFICE NOTES
- ☐ ELECTROCARDIOGRAM (EKG) REPORT
- ☐ LABS
- ☐ STRESS TEST / GXT
- ☐ HISTORY & PHYSICAL FORM
- ☐ ECHOCARDIOGRAM
- ☐ CAROTID DOPPLER
- ☐ OTHER: ______________________

I HEARBY AUTHORIZE CHANDLER CARDIOLOGY ASSOCIATES TO RELEASE ALL OF THE ABOVE REQUESTED INFORMATION RELATIVE TO MY TREATMENT AND CARE TO:

________________________________ ________________________________
COMPANY/PERSON, FACILITY ADDRESS

________________________________ ________________________________
PHONE NUMBER FAX NUMBER

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken in reliance thereon. This consent will expire _______________, or automatically one year from the date of execution. Records released under this authorization shall not be considered part of the records of the receiving facility. Any further disclosure of medical record information by the recipient(s) is not authorized without the specific written consent of the person to who it pertains.

________________________________ ________________________________
SIGNATURE OF PATIENT DATE

____
PHONE NUMBER

____
SIGNATURE OF OTHER AUTHORIZED PERSON

________________________________ ________________________________
RELATIONSHIP TO PATIENT WITNESS