

AUTHORIZATION TO RELEASE MEDICAL RECORDS

First	MI	Last
DOB:	SS:#	
Address:		
City:	State:	Zip:

I hereby authorize Advanced Cardiology, Inc. to receive any and all of my protected healthcare information i.e. medical records that may be available from all Healthcare Providers. Organizations who are in possession of medical records relating to me, are authorized to provide copies of those records to Advanced Cardiology, Inc. via mail or fax.

Patient/Authorized Signature

Print Name

Date