CARDIOLOGY CONSULTANTS OF PHILADELPHIA

Release of Medical Records Form

Date: _____

To: _____
_____
_____

Patient's name: _____
Date of Birth: _____

I, _____, hereby authorize you to release my medical records to Cardiology Consultants of Philadelphia including but not limited to EKG, Stress Test, Cardiac Catheterization, Labs, Carotid Ultrasound, Echocardiogram, chest x-ray.

Please forward my records to: (please enter the address of your appointment)

_____

_____

Patient Signature:_____

_____