REQUEST PRESCOTT CARDIOLOGY TO RELEASE MEDICAL RECORDS

Date:______________________________

Patient's Name:____

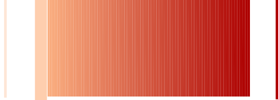
Patient's Date of Birth:___________________________

I, ____, am providing written authorization for Prescott Cardiology to release a copy of my medical records* to the provider/clinic/hospital listed below.

NAME and ADDRESS OF PROVIDER/FACILITY TO RELEASE RECORDS TO:

PRESCOTT CARDIOLOGY

804 Ainsworth Dr, Suite 102, Prescott AZ 86326•PH: (928) 776-0601 •FAX: (928) 776-0620• www.prescottcardio.com



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This authorization includes the release of the following checked records:

____Lab reports ____Diagnostic Test Results ____Progress Notes

____Consultation Notes ____Demographics ____Hospital Records

____All of the Above

____Other:____
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____
Signature of Patient or Authorized Representative

____
Printed Name of Patient

____
Witness

**Please contact Eric at (928) 776-0601 if you have any questions or need assistance in this regard.*