FLORIDA HEART ASSOCIATES

REQUEST FOR RELEASE OF MEDICAL RECORDS FROM:

Florida Heart Associates, PL
1550 Barkley Circle
Fort Myers, FL 33907
Phone (239) 938-2000
Fax (239) 278-0404

I hereby request that my records be released to:

TO:

Physician's Name or Self (please print)

Address

City State Zip Fax# Phone#

FROM:

Print Name

Patient's Signature Date

Address

City State Zip

DOB SS#

Records Requested for Release

- ❑ Catheterization**all
- ❑ Echocardiogram**most recent
- ❑ Nuclear/Stress Test**most recent
- ❑ Labs/Coumadin/Lipids**most recent
- ❑ Office Visit/Consult**last 2
- ❑ PVR**most recent
- ❑ MUGA**most recent
- ❑ Event Monitor**most recent
- ❑ Pacer check/implantation recent
- ❑ Holter**most recent
- ❑ Heart Surg./Vascular Procedures
- ❑ _____

This authorizes Florida Heart Associates, PL., to release any medical, psychiatric, HIV-related and/or substance abuse information from my medical records for the purpose of continuing patient care, by US mail or facsimile.
Any alcoholic or drug abuse information released is protected by Federal Regulations and may not be re-disclosed without specific written consults of the above signed. Any psychiatric information or HIV information released is similarly protected from re-disclosure by Florida Statue.

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Name of FHA staff receiving request

- ❑ Bactes
- ❑ patient pick up