MEDICAL RECORD RELEASE

Patient:____
Address:____
Phone Number:_______________________________________
DOB:____

RE: Release of medical record for continuation of care

Dear ________________________:

Please release my medical records related to treatment for ____________________________ rendered by you or under your supervision from __________________ through ______________________. The information being released should include the following: Cardiac testing, Progress notes regarding Cardiac visits in your office and recent blood work.

This information will be used to further assist in my medical care, and should be mailed or faxed to the following:

Johnstown Heart and Vascular Center
1027 Broad Street
Johnstown, PA 15906

Phone: 814-619-4587

Fax: 814-254-4154

That you in advance for the cooperation with the transition of my records to the office listed above,

Patient signature:____ Date:_________________

Office Staff signature:____ Date:_________________

Please release my medical records listed above within 30 days of the date signed by Patient.