RELEASE OF MEDICAL RECORDS

Patient Full Legal Name:
_____

Gender: _____MALE _____FEMALE **Date of Birth:** _____

Address: _____

_____

Phone: _____

I authorize Pandya Medical Center to: _____OBTAIN my information from:
_____RELEASE my information to:

NAME OF PROVIDER/PRACTICE/FACILITY:
_____

ADDRESS: _____

_____

PHONE: _____

FAX: _____

INFORMATION REQUESTED:

_____All Records
_____Last Office Visit Note
_____Last Blood Work Results
_____EKG, Stress Test, ABI, Cardiac Cath
_____X-Rays/CT/MRI/Ultrasound
_____Immunization Records
_____Other

Authorized Signature: _____ **Date:**____/____/____

If you wish to receive an e-mail communication regarding your health information or records, you acknowledge that you have been advised of the risk of transmission of this information, understand that this is not a secure format, acknowledge that this information may be seen by a third unauthorized party and take full responsibility of the possible security breach.

Phone: 770-709-6922
Fax: 770-709-6910

Updated 10/2020