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.