Cardiovascular Specialists of New England

Medical Records Release

Patients Name _____ Date of Birth: _____

I request and authorize to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

- ☐ All healthcare information
- ☐ Healthcare information relating to the following treatment, condition, or dates: _____
- ☐ Other _____

Patient Signature: _____ Date: _____

Print Patient Name: _____

Witness (If available): _____

This authorization expires two years after it is signed. The patient reserves the right to revoke this release at any time.