Cardiovascular Institute of Palm Beach

Health Information Release Form

I, (patient name): _____ Date of Birth ___/___/___

Doctor/Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ Fax: (____) _____

Please release my health records to:

EH Cardiovascular Institute of Palm Beach
1447 Medical Park Blvd, Suite 101
Wellington FL 33414
Telephone: 561-753-0001 | Fax 561-753-0005

Please include any diagnostic testing results such as:

[] Echo / Stress Echo
[] Labs
[] EKG/ECG
[] Chest X-ray
[] Stress Test
[] Cath/Stents
[] Holter/Event/Telemetry Monitor Reports
[] Pacemaker/AICD/Loop
[] Other: _____
_____

Authorization: I certify that this request has been made freely, voluntarily and without coercion; and that the information provided is accurate and complete to the best of my knowledge.

_____

Print Name Signature Date