Children's Cardiovascular Medicine P.C.

EDUARDO MONTAÑA, JR., M.D., M.P.H.

ICAEL
Accredited Echocardiography Laboratory

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

First Name: _____ Date: _____

Last Name: _____ DOB: _____

I authorize Childrens Cardiovascular Medicine to release my medical records to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Telephone: _____ Fax: _____

I authorize Childrens Cardiovascular Medicine to release my medical records to:

€ All medical sources, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf

Please release the following documentation:

€ Complete Chart
€ Discharge Summaries
€ Consultations
€ Lab Work
€ X-Rays
€ Skin Tests
€ Other: _____

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient Signature:_____ Date: _____

AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

_____ First Request _____ Second Request _____ Third Request

MARIETTA OFFICE: 780 CANTON ROAD NE.SUITE 350.MARIETTA 30060
NORTH FULTON OFFICE: 4310 JOHNS CREEK PKY. SUITE 180. SUWANEE, GA 30024
OFFICE:404-943-0289. FAX: 404-943-9787