CARDIOVASCULAR CONSULTANTS OF SOUTH GEORGIA, LLC

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REQUEST FOR RELEASE OF MEDICAL RECORDS <u>FROM OUTSIDE FACILITY</u>

I, ____, ________________________,
Patient Name (Print) Date of Birth

do hereby request and authorize (**Facility Name, Address, Phone & Fax #**):

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to release information to **Cardiovascular Consultants of South Georgia, LLC**
for the following reason: ☐Continuity of Care ☐Personal Copy ☐Other
☐Insurance Purposes ☐Legal Reasons ☐Transfer to New Provider

DATES OF SERVICE TO BE RELEASED: FROM ____________________ TO ____________________
Records requested: office notes, test results, hospital admissions/discharge summaries, cardiac operative reports

Specific records requested: ____

- I understand that my records have a privileged and confidential status. I am waiving that status for the purpose stated and authorizing the release of information regarding any clinical information including psychiatric, drug, and alcohol abuse/dependence treatment, any information concerning AIDS or HIV testing, or pertinent family medical history that may be a part of the record.
- Please note: Mailing medical records is not a secure method of transmission. While we will honor your request to mail records, we cannot guarantee the confidentiality or security of your information once it leaves our facility.
- I understand that I may revoke this consent at any time unless stipulated above for special condition purposes. Revocation has no effect on action previously taken in reliance on this release.

____________________ ____________________________________ __________________________
Date Patient's Printed Name Patient's Signature

____________________ ____________________________________
Telephone # (Consent of Parent, Spouse, Guardian or next of kin)

01/13/2026