



CARDIOVASCULAR CONSULTANTS

OF SOUTH GEORGIA

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REQUEST FOR RELEASE OF MEDICAL RECORDS FROM OUTSIDE FACILITY

I, _____
Patient Name (Print) Date of Birth

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

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)

08/12/2026