Changes for Life Inc., Theresa Cordova MS, CPT (631) 312-3350 theresa@changesforlife.net

Release of Medical Records

I, ________________________________, authorize: ____________________________________ to disclose/discuss the following medical information with:

Theresa Cordova

I specifically authorize the release of the following:

___ History and Physical ______________________________________

___ Exercise parameters/limitations ______________________________

___ Laboratory Tests ____

___ Electrocardiogram (EKG) ___________________________________

___ Cardiac Function ____

___ Radiology Reports ____

___ Other (specify) ____

I expressly and voluntarily authorize disclosure of the above medical record information. I further understand that I am not giving permission for any disclosure other than described above.

This release is effective for 90 days from the date signed, unless otherwise specified as follows:____

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained for me, or unless such disclosure is specifically required or permitted by law.

______________________________________ ____________________

Signature Date

______________________________________ ____________________

Print Name Patient's DOB