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