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RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ **DOB:** _____

Please send records to:

Name of Practice: _____

Practice Address: _____

Phone Number: _____ **Fax Number:** _____

I request that River City Vascular Specialists release the complete medical records including progress notes, nurse notes, labs/x-ray reports, hospital records and any referral/consult notes on the patient.

- I understand that the release or transfer of the information specified above to any person or entity not specified above is prohibited.**
- I understand that I may revoke this consent at any time except to the extent that this action has already been taken and that it expires 1 year from the date indicated below.**

SIGNATURE: _____ **DATE:** _____

RELATION TO PATIENT: _____