



# CARDIOLOGY CONSULTANTS, LTD.

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## REQUEST FOR MEDICAL RECORDS

### PLEASE PRINT REQUESTED INFORMATION

Patient Name \_\_\_\_\_

Patient SS#: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Records should be delivered to: \_\_\_\_\_

Information or Records Requested: \_\_\_\_\_

I understand that I have the right to access my medical records in accordance with the law and the policies of Cardiology Consultants, Ltd. I understand that Cardiology Consultants may charge me for copies of my medical records, and I have been provided a fee schedule.

I understand that Cardiology Consultants, Ltd. has the right to deny me access to my records in certain circumstances in accordance with the law. If Cardiology Consultants, Ltd. denies me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

*Please note that information disclosed pursuant to this request is no longer under the control of Cardiology Consultants, Ltd., and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Patient Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_