PEARLAND CARDIOVASCULAR ASSOCIATES

# AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patients' name_____ Date of birth _____
PLEASE PRINT

I hereby authorize _____ to release my medical records to:

Pearland Cardiovascular Associates, PLLC
Dr. Rohit Bhuriya, MD, FACC, FSCAI
2530 Broadway Street, Suite C
Pearland, TX 77581
Phone:(713) 436-8883
Fax: (844) 965- 9722

I understand that my express consent is required to release any Healthcare information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and drugs and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and drugs and/or alcohol use, you are hereby specifically authorized to release all information to the above relating to such diagnosis.

Information to be released:

_____ BLOOD WORK _____ EKG _____ ECHO

_____ STRESS TEST REPORTS _____ OFFICE NOTES _____ HOLTER/EVENT REPORT

_____ VASCULAR STUDIES _____ HEART CATHETERIZATION REPORT

_____ OTHERS: _____

Reason records are being released: For Continuation of Care

_____

_____ _____ _____ _____
Signature of Patient/Guardian Printed name Relationship Date