MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

P. O. Box 241587 Montgomery, Alabama 36124-1587
Phone (334) 280-1500 Fax (334) 280-1600
www.mcva.com

MEDICAL RECORD REQUEST

To: Physician Name:_____ Pt Name:_____ DOB:_____

Phone#:_____Fax#:_____ Pt MCVA ID#_____

Treatment Dates requested: _____	__ Echo Report
__ Discharge Summary	__ EKG/Stress Strips
__ History & Physical	__ Holter/Event Monitor
__ Operative Rpt	__ Lab Work
__ ER Record	__ Physician's Progress Notes
__ Stress Test Rpt	__ Physician's Orders
__ Chest X-Ray	__ Other:_____

FAX REQUESTED RECORDS TO 334-280-1600 ATTN:_____

RELEASE OF INFORMATION

Please release the information checked below FROM Montgomery Cardiovascular Associates

To: _____ Address:_____

Phone#:_____ Fax#:_____

Treatment Dates requested: _____	__ Echo Report
__ Discharge Summary	__ EKG/Stress Strips
__ History & Physical	__ Holter/Event Monitor
__ Operative Rpt	__ Lab Work
__ ER Record	__ Physician's Progress Notes
__ Stress Test Rpt	__ Physician's Orders
__ Chest X-Ray	__ Other:_____

Information about you is protected under federal law and you have the right to revoke this Authorization except to the extent that we have taken action in reliance on your Authorization. Please contact the MCA Medical Records Department for an "Authorization Revocation" form if one is needed. By signing below, you recognize that the protected health information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Expiration: Unless otherwise, revoked, this authorization will expire on the following date, event, or condition: If I do not specify an expiration date, event, or condition, this authorization will not expire. Date:____/____/_____

Patient's Signature:_____Date:____/____/_____
As a Personal Representative, I have authority to act for the individual because I am :_____

MCA Witness:_____Date:____/____/_____

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