MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

Mailing Address: PO Box 241587 Montgomery, AL 36124
Phone: (334) 280-1500 Fax: (334) 280-1600
Website: www.mcva.com

MEDICAL RECORD REQUEST

Patient Name: _____DOB: _____

(Physician or Facility) _____

FAX: _____ **Phone:** _____

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: _____ (person completing form)

RELEASE OF INFORMATION

Please release the information checked below from Montgomery Cardiovascular Associates to:
_____ Address:_____ Fax#:_____

Phone#_____

Treatment Dates requested: _____	___ Echo Report
___ Discharge Summary	___ EKG/Stress Strips
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___ 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: _____

MCA Account#_____