CARDIOVASCULAR CARE CENTER &CRC
CARE IS OUR MIDDLE NAME

1372 Wellbrook Circle NE, Conyers GA 30012
Phone: 470-500-CARE (2273) Fax: 470-289-5440

Authorization for the Release of Medical Records

I, _____ DOB_____/_____/_____ hereby authorize the release of all medical records to Cardiovascular Care Center & CRC. I have been provided a copy of Cardiovascular Care Center & CRC's Notice of Privacy Practices and have discussed any concerns I have about the use, release, and disclosure of my health information with appropriate personnel. I understand that Cardiovascular Care Center & CRC assumes no responsibility for the use or misuse by others of health information disclosed under this authorization. I release Cardiovascular Care Center & CRC from all legal liability that may arise from the authorization.

In order for Cardiovascular Care Center & CRC to fully evaluate my health and make informed decisions, I approve the request for copies of all relevant medical records in your file. These copies should include all labs, testing, and last visit notes.

Please send these records to the office address and/or fax number below:

Cardiovascular Care Center & CRC
1372 Wellbrook Circle NE
Conyers, GA 30012
Fax: 470-289-5440

Patient Signature: _____ Date: _____

Signature other than Patient: _____ Date: _____

Signature of Witness: _____ Date: _____