



REQUEST FOR MEDICAL RECORDS TO BE RELEASED TO

THE HEART SHOP

Douglas Rothrock, M.D.

Date: _____

Patient's Name: _____

DOB: _____

I, _____, am providing written authorization for the following provider to release my medical records to Let's Get Healthy 4 You (address and fax number listed above).

Name and Address of Provider/Facility to Release Records to Let's Get Healthy 4 You:

This authorization includes the release of the following checked records:

Lab Reports

Test Results

Demographics

Prognosis

Progress Notes

Consultations

All of the Above

Other: _____

Signature of Patient or Authorized Representative

Printed Name of Patient

Witness

Date

This fax contains medical information, which is considered confidential, personal and privileged. It is intended for the above-named recipient only.
If you have received this fax in error, please destroy it and call us to collect to let us know that you received it.
Thank you.