

Merrimack Valley Cardiology Associates, Inc.

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Patient Authorization For Release of Protected Health Information

Name: _____

Date of Birth: _____

Address: _____

I hereby authorize release of my protected health information (information contained in my medical record) to the following entity.

Merrimack Valley Cardiology Associates, Inc.
Att: Medical Records
27 Village Square, Chelmsford, MA 01824
Phone: 978-256-6607
Fax: 978-250-8189

PLEASE FAX TO: 978-250-8189

Description of information to be Disclosed: ANY OF THE FOLLOWING RECORDS:

- 1: Most Recent Office Visit note
- 2: Recent Blood Lab results/prior EKG
- 3: Any prior cardiac testing:
 - Echocardiograms
 - ETT Stress tests / Nuclear imaging
 - Cardiac Monitor reports
 - Catheterization Reports
 - Cardiac Surgery Reports
 - CT
 - MRI
- 4: Hospital (Cardiology) Consults, & Physical reports, Cardiac reports and Discharge Summaries

Patient/Legal Guardian Signature: _____

If Authorized individual, relationship to patient: _____

Date Signed: _____

Stress Testing Echo and Nuclear Stress Testing Echocardiography Cardiac CT Event Monitoring Holter Monitoring
Pacemaker and Defibrillator Insertion and Management Cardiac Catheterization Angioplasty Interventional Cardiology
Peripheral Vascular Interventions Carotid and Peripheral Vascular Ultrasonography Electrophysiology Evaluation and Therapy

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