



Vishnu Kalidindi, M.D, FACC, FSCAI, MRCP (I)

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Date: \_\_\_\_\_

1. Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone#: \_\_\_\_\_

Persons/organization(s) **providing** records:    Persons/organization(s) **receiving** records:  
(complete address/phone#)

_____	_____
_____	_____
_____	_____
_____	_____

Covering all periods of care from: \_\_\_\_\_ to \_\_\_\_\_

**2. Information to be released:**

\_\_\_\_\_ Copy of complete medical record

\_\_\_\_\_ History and physical

\_\_\_\_\_ EKG report

\_\_\_\_\_ Stress Test

\_\_\_\_\_ Echocardiogram

\_\_\_\_\_ Holter report

\_\_\_\_\_ Other \_\_\_\_\_

3. **Purpose of Disclosure:** \_\_\_\_\_ to send to insurance company

4. \_\_\_\_\_ to send to new general physician

\_\_\_\_\_ to transfer care to a new cardiologist

5. I understand this consent can be **REVOKED** at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

6. Specification of the date, event of condition upon which this consent expires:

---

7. The facility, it's employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Representative

---

Relationship to Patient

Consent for release of patient info 8/2009