California Cardiovascular and Thoracic Surgeons
168 North Brent Street, Suite 508
Ventura, CA 93003
Telephone (805) 643-2375 Fax (805) 643-3511

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Records Requested From: _____
Address: _____
_____

Phone: _____ Fax: _____

PATIENT NAME: _____ DOB: _____

I hereby authorize the release of my medical records/health information. This information may include but is not limited to any treatment or examination rendered to me, radiographic or angiographic studies, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records, HIV test results (if any), *except as specified below:*

_____

_____

Records Being Sent To: _____
Address: _____
_____

Phone: _____ Fax: _____

This Authorization is effective now and will remain in effect until _____
(date)

I understand that I may obtain a copy of this authorization.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:
[ ] parent or guardian [ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient