MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

H Forrest Flemming, MD
David N George, MD
Paul B Moore, MD
Wynne Crawford, MD

R Eric Crum, MD
Beverly A Stoudemire-Howlett, MD
Darryl A Hamilton, MD
Jose L Escobar, MD

Tamjeed Arshad, MD
Iliana Arellano, MD
M Todd Miller, MD

273 Winton M Blount Loop P. O. Box 241587 Montgomery, Alabama 36124-2398
Phone (334) 280-1500 Fax (334) 280-1600
www.mcva.com

MEDICAL RECORDS RELEASE FORM

To:
Physician Name: _____ Pt Name: _____DOB_____

Fax #:_____ Pt. MCA Acct #:_____

Portions of Record Needed-----Check Applicable Sections

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Rpt
- ☐ ER Record
- ☐ Stress Test Rpt
- ☐ Chest X-Ray
- ☐ Echo Report
- ☐ EKG/Stress Strips
- ☐ Holter/Event Monitor
- ☐ Lab Work
- ☐ Physician's Progress Notes
- ☐ Physician's Orders
- ☐ Other:_____

FAX REQUESTED RECORDS TO 334-280-1600
ATTN: MEDICAL RECORDS

Treatment Dates requested: _____

Information about you is protected under federal law and you have the right to revoke this Authorization except to the extent that we have taken action in reliance on your Authorization. Please contact the MCA Medical Records Department for an "Authorization Revocation" form if one is needed. By signing below, you recognize that the protected health information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Expiration: Unless otherwise, revoked, this authorization will expire on the following date, event, or condition: If I do not specify an expiration date, event, or condition, this authorization will not expire. Date: ____/____/_____

Patient's Signature:_____ Date: ____/____/_____
As a Personal Representative, I have authority to act for the individual because I am :_____

Witnessed by:_____ Date:____/____/_____

FOR MCA USE ONLY:

- ☐ RELEASE HAS ALREADY BEEN FAXED TO PHYSICIAN LISTED ABOVE
- ☐ RELEASE NEEDS TO BE FAXED TO PHYSICIAN LISTED ABOVE
- ☐ RELEASE NEEDS TO BE SCANNED TO PT CHART