MEDICAL RECORDS RELEASE FORM

Patient Information:

Full Name: ____
Date of Birth: ____
Address: ____
Phone Number: ____
Email Address: ____
I, ____________________, hereby authorize the release of my medical records from:

Healthcare Provider/Facility Name: ____________________________________
Address: ____
Phone Number: ____

To:

Recipient Name: ROWAN CARDIOLOGY
Address: 689 SIERRA ROSE DR UNIT B RENO, NV 89511
Phone Number: 775-636-7100
Fax Number: 775-636-6724
Email Address: CONTACT@ROWANCARDIOLOGY.COM

Purpose of Release:
[ ] Continuity of Care
[ ] Second Opinion
[ ] Legal/Court Proceedings
[ ] Personal Records
[ ] Other

Types of Records to be Released (Check all that apply):
[ ] Medical History
[ ] Consultation Notes
[ ] Progress Notes
[ ] Test Results (e.g., lab reports, imaging studies)
[ ] Treatment Plans
[ ] Medication Records
[ ] Immunization Records
[ ] Other

Date Range of Records to be Released: From ______________ To ______________

I understand that:

The information disclosed may include sensitive and confidential medical information.
Once disclosed, my medical records may no longer be protected by federal or state privacy laws.
I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization.
Patient Signature: ______________________________ Date: ________________

Parent/Legal Guardian Signature (if applicable): ___________________ Date: ________________