



The Heart & Vein Center

Specializing in Cardiology & Vascular Disease

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ATTN: Medical Records

Patient: _____ DOB: ____/____/____

Physician: _____

Phone: (____) _____

Fax: (____) _____

- We need the following medical records to assist in the care of your patient.
- Patient requesting, we send records to you.

- Latest office /Progress Notes, Hospital Admissions, Discharge Summaries.
- Latest Lab Report
- Medication List
- Any Diagnostic Testing
- Other: _____

Record Period: From _____ to _____

Patient Appointment is on: _____ @ _____ am/pm

Please add the following to access my records or speak on my behalf.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

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