

Park East Cardiovascular
158 East 84th Street
212-535-6340 Telephone
212-535-2618 Facsimile

Authorization for Release of Information

Name: _____ **D.O.B.:** _____

I hereby authorize Park East Cardiovascular, P.C. to:

Mark B. Schiffer, MD, FACC
Paul P. Romanello, MD, FACC
Ira S. Blaufarb, MD, FACC
Donna A. Ingram, MD, FACC
Nicholas B. DuBois, MD, FACC

Check **ONE** option:

Release my records to **Obtain my records from**

Sandy Iannarone, MBA, MHA
Practice Administrator

Verbally exchange my records with

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Please check all that apply:

1. _____ Stress Thallium Report
2. _____ Echocardiography Report
3. _____ EKG
4. _____ Stress Test
5. _____ All Medical Records
6. _____ Other information _____

For the specific purpose of: _____

This authorization will expire one year from the date of my signature. I understand that this authorization may be revoked by me in writing at any time, except to the extent that action has already been taken.

Patient's Signature: _____ Date: _____

Parent/Guardian, if minor: _____

Witness: _____