Paul W. Dlabal, M.D., FACP, FACC, FAHA
Cardiovascular Research Associates, PA
300 Beardsley Lane Suite C-101
Austin, TX 78746
Phone 512.454.3333 Fax 888.894.0872

To:_____

Phone:_____

FAX:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name :_____

Date of Birth :_____

For the purpose of continuation of care, I request that my original file complete with all documentation and medical records (including progress notes, x-rays, cath & operative reports, lab reports, treadmill results, ekg(s), echocardiogram results, nuclear imaging results and other treating physician records and correspondence, etc.) be released to:

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Cardiovascular Research Associates, PA
300 Beardsley Lane Suite C-101
Austin, TX 78746
Phone 512.454.3333 Fax 888.894.0872

_____

Signature of Patient or Legal Representative

_____

Date