SHACHTER CARDIOLOGY, LLC

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MR#______________________

MEDICAL RECORDS RELEASE FORM

I, ____________________________________, request that my medical records be

released **TO Dr. Neil Shachter** **fax# (561) 637-6035**

FROM ____________________________ **fax#**_______________

The following records are to be sent:

______ EKG
______ Cardiac Tests
______ Lab Results
______ Progress Note(s)
______ Entire Record

From: ____________ to _____________
Date Date

Records should be sent via:

_____ Mail _____ Fax _____ Pick-up (on _________________)
Date

____
Patient's Signature

____
Date

____
Patient's Social Security #

____
Patient's D.O.B.

____
Witness

____
Date