



## AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

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Dear Doctor \_\_\_\_\_,

We have the pleasure of providing cardiology care to:

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Please fax copies of the following to (818) 784-1531  
or mail to:

**Pediatric Cardiology Medical Associates**  
**5400 Balboa Blvd., Suite 202**  
**Encino, CA 91316**

- Complete medical records
- Cardiac catheterization data and/or surgical reports
- Copies of electrocardiograms tracings
- Echocardiogram reports and copies of echocardiogram tape or CD ROM
- Chest X-Ray films (to be returned)

Patient or guardian name (print): \_\_\_\_\_

Patient or guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_