EASTERN CARDIOLOGY, P.A.

Eric B. Carlson, M.D., FACC, FSCAI, Mary Jo Bertsch, M.D., FACC, Noel Peterson, M. D.

MEDICAL RECORD RELEASE

Date: ____________________

I hereby authorize: ____
(Name of practice and address)

____

____

To release my medical records including the diagnosis and record of any treatment or examination rendered to me at any time to:

EASTERN CARDIOLOGY, P. A.
2090 B WEST ARLINGTON BOULEVARD
GREENVILLE, N. C. 27834-5727

TELEPHONE – 252-757-3333 or 252-758-3000
FAX # 252-752-1786 or 252-758-7107

________________________________ ________________________________
Patient's Name (Please print or Type) **Patient's Signature**

____
Patient's Date of Birth

________________________________ ________________________________
Patient's Social Security Number **Witness Signature**

____
Patient's Address

____
City/State/Zip Code

Records: ______Faxed______Mailed______Released to Patient: Date_________Initials_______

(Medical Records Release)
(Revised 11-2010)