HEALTHY HEART CARDIOLOGY | MOHAMED S. RAHMAN, M.D.
Board Certified Electrophysiologist & Cardiologist

# ***Consent to Release Information***

*Patient Name:*______________________________________

*Phone Number:*_____________________________________ *DOB:*____________________

*Address:*__________________________________________________________________

I hereby authorize Healthy Heart Cardiology and its staff to release medical records to the following people and/or doctors/facilities:

| *Name* | *Relation* | *Phone Number* |
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Please release a copy of medical records, including progress notes, labs/x-ray results, latest hospitalization records, and/or testing. I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose, this consent will automatically expire.

*Signature:*__________________________________________ *Date:*__________________

Healthy Heart Cardiology
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