

**SOUTH CHARLESTON CARDIOLOGY, LLC**

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**CONSENT TO RELEASE MEDICAL RECORDS**

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PATIENT'S NAME: \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby authorize you to release my medical records. These records will be sent or picked up by the patient for review by :

Dr. \_\_\_\_\_

Address: \_\_\_\_\_

I HEREBY RELEASE SOUTH CHARLESTON CARDIOLOGY LLC FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT THAT I HAVE AUTHORIZED.

Patient Signature/Power of Attorney \_\_\_\_\_

Date \_\_\_\_\_

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