Authorization for Disclosure of Confidential Information

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Address: _____

I hereby authorize Nasser Cardiology, P.A. to:

- **Release to**
- **Receive from**

Name of Person or Facility: _____

Street Address: _____

City, State, Zip _____ **Phone:** _____

Fax: _____

- **History and Physical**
- **Lab Results**
- **Cath Reports**
- **Radiology Reports**
- **Nuclear Stress Test**
- **Echo Doppler**
- **EKG**

PATIENT SIGNATURE: _____

DATE: _____

- **ALL RECORDS**