Southern Cardiovascular Care, PC

1800 Fairview Avenue, Suite 1
Dothan, AL 36301
Phone: 334 699-8900
Fax: 334 699-7498

# Medical Records Release Form

**I_____(First)_____(Middle)_____(Last name)**

**Date of Birth _____/_____/_____/(Month xx/Day xx/Year xxxx)**

**Give permission to Dr.Srinivasa R. Chennareddy and Southern Cardiovascular Care, PC to obtain my medical records from_____**

**Permission to Obtain My Medical Records in the Transfer of Care from Southern Cardiovascular Care, PC to _____**

**Signed:**

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**Patient Signature or Authorizes Representative** **Date**

**Types of records requested: Any and all records for the above named patient, including doctor notes, clinic notes, lab and radiology reports, medication summary, procedure notes, nurses notes.**

**_____: Please follow the agreed upon procedure for transfer. Thank you for your cooperation in this matter.**

*Please Bring all medications and insurance cards. Please be prepared to pay your co-pay.*