Downriver Heart & Vascular Specialists

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Date:_____

From: Downriver Heart and Vascular Specialists

I hereby authorize release of all of my medical records associated with my cardiac history and treatment records from the time period of _____ to _____

To (facility/office name):_____ .

Fax Number:_____ Phone Number:_____

Patient Name: _____ DOB:_____
(please print)

X_____ X_____
Patient Signature Witness Initials

X_____ X_____
Signature of relative/authorized representative Relationship