MEDICAL RECORD RELEASE AUTHORIZATION
Pacific Coast Heart Center
Christine M. Theard M.D.

PATIENT NAME: ____

DATE OF BIRTH: ____________________

I request and authorize medical records of the patient named above to be released from:

MEDICAL OFFICE NAME: ____

PHYSICIAN'S NAME: ____

STREET ADDRESS: ____

CITY, ST, ZIP: ____

PHONE: ____________________

FAX: ____________________

DATE OF SERVICE(S): ____________________

- ☐ Discharge Summary and Testing Results
- ☐ Other ____

____ ____________________

Patient Signature Date:

<u>PLEASE FAX TO: 949-495-0805</u>

Pacific Coast Heart Center
33971 Selva Road Ste 250
Dana Point, CA 92629
Office: 949-495-0800