California Heart & Vascular Clinic
Athar Ansari, M.D., INC. Cardiology
790 W. Orange Ave., Ste. B
El Centro, CA 92243

Phone: (760) 353-3222
Fax: (760) 353-3311

CONSENT TO RELEASE INFORMATION

_____ Fax#: _____

_____ Phone#: _____

_____ From: _____

Number of pages: 1

Patient Name: _____ Date of Birth: _____

Dear: _____

Please forward the following information to Athar Ansari, M.D., INC.

- ☐ Complete Medical Records
- ☐ Summary of Records
- ☐ X-rays, laboratory studies, EKG, _____
- ☐ Other: _____

_____

I have read carefully and understand the foregoing. I consent to the release of the above specified information or medical records of my condition and of the treatment services I have received from those persons or agencies listed above. I authorize my attending physician and his associates the release of this information or records to such designated persons or agencies.

_____ _____

Patient's signature or legal guardian Date

I hereby certify that it is my opinion that the above signed understands that nature of this release of information or records and is otherwise competent to consent thereto.

_____ _____

Witness Date