



California Heart & Vascular Clinic  
Athar Ansari, M.D., INC. Cardiology  
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El Centro, CA 92243

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# 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

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