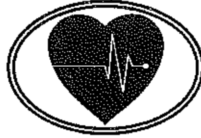

Dr. Abas A. Amiry, M.D., FACC, FSCAI

Amiry Cardiology Consultant MDSC

102A Fox Glen Court
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Phone: 224-848-4353
Fax: 224-848-4367

Authorization for Release of Health Information

DATE ___________________________

I hereby authorize Amiry Cardiology Consultants MDSC to release/obtain my records to/from:

____

____

____

Include any test results, diagnosis and records of any treatment or examinations rendered to me during the period from _______________ to _____________.

I understand that I will be charged a fee to released/copy my medical records.

I understand that I have the right to revoke this Authorization in writing at any time.

This Authorization will expire 3 months to the date indicated on this form.

PATIENT NAME (PLEASE PRINT) _________________________________

DATE OF BIRTH_________________________

PATIENT SIGNATURE ____

WITNESS SIGNATURE ____