

NSC Cardiology Inc – www.heartdrsingh.com

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REQUEST FOR RELEASE OF MEDICAL RECORDS

This form to be used if we need to get records from a previous physician or previous hospital stay

TO : NAHVC AHS Other

I hereby request that all my medical records be released to NSC Cardiology Inc promptly.

Patient Name: _____ **Date:** _____

DOB: _____ **SSN:** _____

Address: _____

Patient Signature: _____

Georgia law, (O.C.G.A. § 31-33-2(a)(2)), requires a physician to provide a current copy of the record to the patient under most circumstances. Also, O.C.G.A § 31-33-2(b) allows a patient or his/her designee to receive a copy of the requested record(s).

PLEASE FAX TO 888-814-0852

OR E-Mail to Katie@nsccardiology.com