Ki Hassler D.O., F.A.C.C.
1215 Jacaranda Blvd
Venice, FL 34292
Phone: 941-451-8282
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Medical Records Request Form

Patient Name: _____ **Date of Birth**: _____

By signing this form, I authorize **Ki Hassler DO, FACC Cardiology** at (Phone) 941-451-8282 to release confidential health information about me, by releasing a copy of medical record, to the physician/person/facility/entity listed below.

The information you may release is as follows:

Complete Records	Hospital Records
History & physical	Care Plan
Progress Notes	Labs
Radiology Reports	Diagnostic Reports
Cardiac Procedures	X-rays
Medication Records	Other _____

The Purpose for this release of information is: _____

Release the requested information to the following physician/person/facility/entity:

_____

_____

_____

_____

*please provide fax number

Signature _____ Relationship to Patient _____ Date _____