MOHAMED S. RAHMAN, M.D.
Board Certified Electrophysiologist & Cardiologist

Consent to Release Information

*Patient Name:*_____

*Phone Number:*_____ *DOB:*_____

*Address:*_____

I hereby authorize Healthy Heart Cardiology and its staff to release medical records to the following people and/or doctors/facilities:

Name	*Relation*	*Phone Number*

Please release a copy of medical records, including progress notes, labs/x-ray results, latest hospitalization records, and/or testing. I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose, this consent will automatically expire.

*Signature:*_____ *Date:*_____

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