

CARDIOLOGY CONSULTANTS OF TEXAS
Diagnostic and Interventional Cardiology

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RECORDS TRANSFER REQUEST

DATE: _____

To: _____
(Doctor/Hospital)

Address: _____

City: _____ State: _____

I hereby authorize the release of my _____
or copies of such and request that they be referred to:

Cardiology Consultants of Texas
9101 N. Central Expressway Suite 300C
Dallas, Texas 75231

Telephone: 469-800-7400
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Patient Name: _____ DOB: _____

Social Security Number: _____

Signature (*patient, parent, or guardian*)

Doctor's Appointment

Doctor's Review

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