AUTHORIZATION TO OBTAIN, USE AND/OR DISCLOSE HEALTH INFORMATION

I, ____ hereby authorize
(Patient / Legal Representative)

____to release copies of all
(Health Care Provider you wish to obtain records from)

medical records of: ___________________________. _________________________
(Patient's Name) (Social Security Number)

for the purpose of treatment to:

Cardiovascular Interventions, P.A.
Pradip Jamnadas, MD, MBBS, FACC, FSCAI, FCCP, FACP
1900 North Mills Avenue
Orlando, FL 32803
Phone: (407) 894-4880
Fax: (407) 894-2364

____
____
(Patient / Legal Representative Signature) (Date of authorization)

________________________ ___________________
(Patient's Date of Birth) (Telephone Number)

If you have any questions regarding this request, please contact Jackie or Angie at 407-894-4880.