



Records Release Authorization (Please complete all sections)

This record release authorization allows us to obtain your records from your primary/other physicians, to be given or sent to The Heart Center.

Release To: _____ **Date:** _____
Physician or Hospital

Address: _____ **Phone #:** _____
City/State/Zip Code

I hereby authorize and request that you release to: **The Heart Center**, the complete history medical records in your possession, concerning my illness and/or treatment during the period from _____ to _____
Date Date

Name: _____ **Address:** _____

Signature: _____ **Date:** _____
(If relative, enter relationship)

This record release authorization allows **The Heart Center** to release your medical records to other physicians or medical facilities.

Release To: _____ **Date:** _____
Physician or Hospital

Address: _____ **Phone #:** _____
City/State/Zip Code

I hereby authorize and request that you release to: **The Heart Center**, the complete history medical records in your possession, concerning my illness and/or treatment during the period from _____ to _____
Date Date

Name: _____ **Address:** _____

Signature: _____ **Date:** _____
(If relative, enter relationship)

The Heart Center Locations:

1 Columbia Street
Poughkeepsie, NY 12601
Phone # (845) 473-1188

939 Little Britain Road
New Windsor, NY 12553
Phone # (845) 567-1800

200 Westage Business Center Drive
Suite 111
Fishkill, NY 12524
Phone # (845) 897-9760

28 Springbrook Park
Rhinebeck, NY 12572
Phone # (845) 876-0508

222 Route 299
Highland, NY 12528