

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
621 N. Hall St. Suite 400
Dallas, Texas 75226

Telephone: (214) 824-8721
Fax: (214) 237-6556

Patient Name: _____ DOB: _____

Social Security Number: _____

Signature (*patient, parent, or guardian*)

Doctor's Appointment

Doctor's Review

621 N. Hall, Suite 400
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214-824-8721

4211 Joe Ramsey Blvd., Suite 108
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