

**CARDIOLOGY CONSULTANTS OF TEXAS**  
**Diagnostic and Interventional Cardiology**

**RECORDS TRANSFER REQUEST**

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**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

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