

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

**RECORDS TRANSFER REQUEST**

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Rajan Singh, MD  
Haojie Wang, MD

**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**  
**1305 W. Jefferson Suite 100**  
**Waxahachie, Texas 75165**

**Telephone: (972) 923-7292**  
**Fax: (972) 923-8089**

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

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