



**STATE
OF THE
HEART**
CARDIOLOGY

John A. Osborne, M.D., Ph.D., F.A.C.C.
3801 William D. Tate
Suite 850
Grapevine, Texas 76051
817-310-3070

TODAY'S DATE: ____/____/____

RELEASE OF MEDICAL INFORMATION
(PLEASE PRINT)

Patient's Full Name: _____
(First / MI / Last)

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Telephone Number: () _____ - _____ Date of Birth ____/____/____ Social Security No _____ - _____ - _____

I hereby request that my complete medical records be released to Dr. John A. Osborne for his use in my medical care. This consent is only for the release of medical records and should include all medical notes, lab studies, surgical reports, x-ray reports, EKG's and other diagnostic reports. Please expedite my request and mail my medical records to -

Name of Recipient: John A. Osborne, M.D.

Address: 3801 William D. Tate; Suite 850

City & State: Grapevine, Texas Zip Code: 76051

Signature of patient or authorized representative

Date:

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Unless otherwise revoked, this Authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have any questions about disclosure of my health information, I can contact Cherrie Crawley at 972-739-3070.