NEVADA CARDIOLOGY ASSOCIATES

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BOARD CERTIFIED CARDIOLOGISTS

Medical Records Release

____ **I wish** to participate in electronic health exchanges, hospitals, healthcare facilities and clinics to release and obtain my medical records to and from Nevada Cardiology Associates.

____ **I DO NOT wish** to participate in electronic health exchanges, hospitals, healthcare facilities and clinics to release and obtain my medical records to and from Nevada Cardiology Associates.

_____

Patient signature

_____

Patient Name (Print)

_____

Patient DOB

_____

Today's Date

_____

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