Advanced Heart Care, LLC

4600 Memorial Drive, W3
Belleville, IL 62226
618-222-8900 Fax 618-222-8950

Authorization to Release Medical Information

Patient Name: _____ DOB:_____/_____/_____

Date of Service: _____

Requested Information: _____

I_____authorize_____
(Patient Name) (Name of Practice releasing information)

to release information contained in my medical record concerning treatment provide from

_____ to *ADVANCED HEART CARE*. I understand that this is a required consent and I voluntarily and knowingly sign this authorization for release of information to:

Dr. Omar Almousalli M.D.
4600 Memorial Drive, W3
Belleville, IL 62226
618-222-8900(Office); 618-222-8950 (Fax)

I release _____ from any liability arising from the release of (Name of Practice releasing information) information to the individual or agency stated above.

Patient signature: _____Date:_____/_____/_____

Witness signature: _____Date:_____/_____/_____