AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Perioperative Telehealth Evaluations™

Patient Information
Full Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Records Requested
■ History & Physical [ ]
■ Anesthesia Records [ ]
■ Discharge Summary [ ]
■ Labs [ ] _____

■ Imaging [ ] _____
■ EKG [ ] Most Recent
■ Stress Test [ ] Most Recent
■ Holter Monitor [ ] Most Recent
■ Echo [ ] Most Recent
■ Myocardial Perfusion/SPECT [ ] Most Recent
■ CT Calcium Scoring [ ] Most Recent
■ Pacemaker Interrogation [ ] Most Recent
■ Angiogram [ ] Most Recent
■ Carotid Ultrasound [ ]
■ Lower Extremity Ultrasound [ ]
■ Carotid Ultrasound [ ]
■ Other [ ] _____

Please Fax the following requested documents to (209) 379-8098
OR
Please Email the following requested documents to perioptelehlth@gmail.com

For question or concerns please call (650) 431-5304

Purpose

■ Preoperative Evaluation
■ Patient Request

Authorized Parties
From: _____
To: Perioperative Telehealth Evaluations™

Signature
Signature: _____ Date: _____