LAS CRUCES CARDIOLOGY

AXEL ZAGLER-LUNA, MD
BOARD CERTIFIED IN CARDIOVASCULAR DISEASE, INTERVENTIONAL CARDIOLOGY, ECHOCARDIOGRAPHY AND CARDIOVASCULAR COMPUTED TOMOGRAPHY (CT)

RECORDS RELEASE/REQUEST/AUTHORITY

Patient Name: _____ Patient DOB:_____

I hereby request that my medical records be released from:

Provider/Facility:_____
Address:_____
Phone: _____Fax:_____

To: **Las Cruces Cardiology**
FAX MEDICAL RECORDS TO: 575-521-3520 if more than 10 pages.
If 10 pages or fewer, FAX TO: 575-386-4199.
If unable to fax, mail to:
4371 E. Lohman Ave., Suite 3A
Las Cruces, NM 88011

RECORDS REQUESTED ARE AS FOLLOWS:

_____Laboratory, X-ray, EKG reports
_____Office notes, procedures reports
_____Inpatient/outpatient: procedure, admit, consultation and discharge reports
_____ER reports
_____Cardiac reports such as: Cath, echo, stress tests, holter w/full disclosure & tracings.
_____Vascular reports
_____ Other records _____

This does not include records of treatment for drug/alcohol abuse and/or psychiatric illness and or AIDS and/or HIV. In authorizing release of information regarding treatment of psychiatric illness, I understand that I have a right to examine and copy and information disclosed under the terms of this release.

_____

Signature Date