MASSACHUSETTS
GENERAL HOSPITAL

HARVARD
MEDICAL SCHOOL

AllCare Medical at Levinson Harris Medical Group
535 Boylston Street, 7th Floor
Boston, Massachusetts 02116
Tel: (617) 247-0666
Fax: (617) 247-9444

John R. Levinson, MD, PhD
Internal Medicine & Cardiology

MEDICAL RECORDS/X-RAY RELEASE AUTHORIZATION

To the patient: Please copy this form and execute a signed original for *every* physician and hospital having medical records relevant to your medical history.

To:
Doctor / Hospital: ______________________________

Address ______________________________

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I hereby authorize and request you to release to Dr. Levinson's office at the address above, the following medical information.

- ☐ Complete medical records
- ☐ Cardiac cath reports
- ☐ Cardiac cath films/CDROMs
- ☐ Cardiac surgery reports
- ☐ Other cardiac data (stress, Holter, echo, etc.)
- ☐ Pacemaker data
- ☐ Hospital discharge summaries
- ☒ All of the above

NOTE: ☐ Dates of interest: ______________ until ______________ OR
☒ All dates

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health issues, or drug and alcohol use. If I have been tested, diagnosed or treated for any of the aforementioned issues you are specifically authorized to release all information relating to set issues.

Patient name (please print) ______________________________

SS #______________________ date of birth ______________

Address ______________________________

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Signature & Date

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Witness Signature & Date