The Cardiovascular Care Group

Experience, Integrity, Innovation - Since 1963

Proudly Featuring the Vein Institute of New Jersey

PATIENT RECORD REQUEST

Patient Name_____ DOB:_____ Phone #_____
(print)

I _____hereby request the following:
Patient and/or Patient Representative

____ Specific records (please specify) _____ or _____ All records

____ To receive a paper copy of my record

____ To receive an electronic version of my record in the form and format indicated below:

_____

To be mailed/emailed/faxed to: _____

_____

All record requests must be submitted in writing to The Cardiovascular Care Group. If approved, an agreed upon date, time and place will be scheduled. If the electronic form and format requested is not readily producible by The Cardiovascular Care Group in such form and format requested, then The Cardiovascular Care Group will provide a readable electronic form and format as agreed. If the request is denied, the patient and/or patient representative will be informed as to the reason why.

Requests for records can be mailed, faxed or emailed to:

The Cardiovascular Care Group
673 Morris Ave.
Suite 201
Springfield, NJ 07081
Email: info@tcvcg.com
Fax# 973-759-2487

Authorized Signature:_____ Date: _____
Patient and/or Patient Representative

For Office Use Only:

Received By:_____ Date Received:_____