California Heart associates
A Medical Group

Nicolas N. Doan Van, MD, FACC, Inc.
Robert S. Greenfield, MD, FACC, FAHA, FNLA, Inc.
Arvind S. Nirula, MD, FACC, FSCAI, Inc.
Sanjiv M. Patel, MD, FACC, FSCAI
Steven M. Schiff, MD, FACC, Inc.
Surinder S. Thind, MD, FACC, FSCAI
Jennifer Lee Wong, MD, FACC, Inc.
Amanda M. Donohue, DO
Sarah Elsayed, MD,FACC, FSCAI,RPVI
Tae Yang, MD
Hoang Nguyen, MD
Nikhil Warrier, MD
Kerry Wood, NP-C

Medical Records Release Form

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I authorize and request you to release records to:

California Heart Associates

Attn: Dr. _____

A copy of all my medical records, unless specified below:

_____

_____

Print Name: _____ Signature: _____

DOB: _____ Date: _____

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Fountain Valley • 18111 Brookhurst St., Suite 5100 • Fountain Valley, CA 92708 *(714) 546-2238 Fax (714) 434-8145*
Santa Ana / HCP • 3501 S. Harbor Blvd., Suite 140A • Santa Ana, CA. 92704 *(714) 274-1427 Fax (714) 274-1433*
Irvine • 4950 Barranca Parkway, Suite 210 • Irvine, CA 92604 *(949) 208-6936 Fax (949) 208-6940*