CENTER OF THE HEART
Edward R. Assi DO·PA
FACC · FSCAI BOARD CERTIFIED IN CLINICAL AND INTERVENTIONAL CARDIOLOGY

P:915.577.9009
F:915.577.9006
1700 Cliff Bldg. A Ste. 200
El Paso, TX 79902

PATIENT-CENTERED CARDIAC CARE

AUTHORIZATION TO TRANSFER RECORDS FROM

EDWARD ASSI, D.O., P.A.

I HEREBY AUTHORIZE YOU TO TRANSFER OR MAKE AVAILABLE TO:

_____

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PLEASE PRINT

PATIENT NAME_____DOB_____

ADDRESS:_____

CITY, STATE, ZIP _____

SS# _____ - _____ - _____

SIGN / DATE _____

TYPE OF RECORDS REQUESTED:

ALL_____ LAB_____ EKG_____

X-RAYS_____ OTHER_____

TREATMENT FROM: _____ TO _____

CAUTION: CONTAINS CONFIDENTIAL HEALTH CARE INFORMATION

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