THE ADVANCED CARDIOVASCULAR CENTER OF TAMPA BAY, P.A.

4700 N. Habana Ave. Suite 100 Tampa, FL 33614
Phone: 813-875-9900

PATIENT MEDICAL RECORDS REQUEST FORM

PATIENT NAME:____DOB:____/____/____

SS NUMBER:______________________PHONE NUMBER:______________________________

PATIENT CURRENT
ADDRESS:____

____

RECORD(S) REQUESTED:____

DATE(S) OF SERVICE (mm/year): _______/_________ - ________/_________

PREFERRED METHOD OF DELIVERY? Please check one.

- ○ Hard Copy mailed to address provided above.
- ○ Pick up in person at office location with Identification:
  4700 N. Habana Ave. Suite 100 Tampa, FL 33614

Please submit this completed form, in addition to a copy of a valid government issued identification. For any questions or concerns, please call our office.

Patient Signature:____ Date:__________________