Saba Thangam, MD

533 Medical Oaks Dr
Brandon, Fl 33511
(813) 295-5800

HEART & VEIN CENTER , P.A.

Diagnostic, Interventional and Consultive Cardiology

DATE _____

TO _____

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I request that a copy of my medical records be released to:
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_____ **Saba Thangam, M.D.**

Please send to: **Heart & Vein Center, PA**
533 Medical Oaks Dr
Brandon, Fl 33511
Fax (813) 689-8811

I hereby authorize you to send any and all medical records, especially reports on cardiac catheterizations, PTCA's and CABG's.

In addition, I also authorize Heart & Vein Center,P.A. to provide copies of the results of any special procedures performed to my referring physician as noted in my records.

A copy or fax of this authorization may be used in lieu of the original.

_____ _____
Patient Name (PRINT) **Date of Birth**

_____ _____
Patient Signature **Social Security Number**