VILLAGE Heart & VEIN CENTER

8575 NE 138th Lane

Suite 203

Lady Lake, FL 32159

Georg Couturier MD, FACC
Bryan Carter MPA-C
Renee Schafer APRN

Saroj Tampira, MD, FACC
Erica Harden, APRN

Sujata Balulad, MD
Jennifer Koeller, PA-C
Scott Wojciechowski PA-C

# Preliminary Patient Information Sheet

Patient Name_____ Date of Birth _____

Street Address_____

City_____ ST_____ Zip Code_____

Contact Number_____ Male_____Female_____

## Primary Insurance

Insurance Company_____Phone Number _____

Subscriber number _____Group#_____

## Secondary Insurance

Insurance Company_____Phone Number _____

Subscriber number _____Group#_____

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Schafer APRN Scott Wojciechowski PA-C

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# Authorization to Release Medical History

I request and authorize the following health care providers to release healthcare information of the patient named above. Please provided your last progress note and all cardiac testing

Primary Care_____ PH_____FX_____

Other Providers_____PH_____FX_____

Other Providers_____PH_____FX_____

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to
the person(s) listed above.

Patient Signature:_____Date_____

Last four digits of social security_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.