Heart & Vascular Center
of Arizona

Noninvasive, Invasive and Interventional Cardiology, Peripheral Vascular Disease Electrophysiology and Women's Cardiology

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Nuclear Cardiology Accredited Nuclear Cardiology Laboratory

ICAEL Accredited Echocardiography Laboratory

CARDIOLOGY PRACTICE RECOGNITION™ Endorsed by the American College of Cardiology

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth:_____

Address: _____ Social Security #: _____-____-_____
_____

Home Phone #: (___)_____-_____ Work Phone #:(___)____-_____

I hereby authorize _____ to send/release photocopies of medical records concerning the above named patient to:

Heart and Vascular Center of Arizona
1331 North 7th Street, Suite 375
Phoenix, Arizona 85006

For the purpose of: _____ I authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of _____ its employees and/or agents. FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661) CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-611),CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

_____ Medical Records
_____ Hospital Records of _____ (IP) (OP)
_____ Cath Lab Reports
_____ Electrocardiograms
_____ Laboratory Reports
_____ Other _____

This consent will expire sixty (60) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify my health plan in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Patient Signature Date

_____ _____
Parent/Legally Authorized Representative Relationship to Patient