

# Heart & Vascular Center of Arizona



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

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*Medical Director*

E.C. BARRETO, MD  
*In Memoriam*

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PARMINDER SINGH, MD, FACC  
REBECCA ALLISON, MD, FACC  
JOSHUA WAGGONER, MD  
*Interventional Cardiology*

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*Noninvasive Cardiology*

ASHISH SADHU, MD, FHRS, FACC  
*Electrophysiology*

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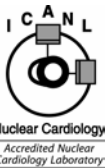
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## AUTHORIZATION TO RELEASE MEDICAL RECORDS

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 7<sup>th</sup> 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

