Affiliated Cardiologists of Arizona

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AUTHORIZATION TO RELEASE RECORDS

Patient Name: _____ **Address:** _____

DOB: _____ _____

Phone (Home/Cell) _____ _____

I hereby authorize **Affiliated Cardiologists of Arizona** to send/release photocopies of medical records, as marked below, concerning the above-named patient to:

_____

_____

For the purpose of: _____

FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" 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.

___ **Office Notes** ___ **Hospital Records** ___ **EKGs/Testing** ___ **Laboratory Reports**

Dates of Service: _____

ONLY PHOTOCOPIES OF THE ITEMS CHECKED ABOVE WILL BE SENT
Please allow 7-10 business days for copies to be mailed/picked up.

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