

Affiliated Cardiologists of Arizona

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AUTHORIZATION TO RELEASE RECORDS

Patient Name: _____

Address: _____

DOB: _____

Phone (Home/Cell) _____

I hereby authorize the release of photocopies of medical/hospital records, EKGs, testing, lab reports and any other records (as indicated below), in the possession/control of _____ regarding the above-named patient to:

**AFFILIATED CARDIOLOGISTS OF ARIZONA
1331 N. 7th Street, Suite #400
Phoenix, Arizona 85006**

For the purpose of: CONTINUING MEDICAL CARE

FOR THE PURPOSES HEREOF, "MEDICAL/HOSPITAL 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: _____

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