Phoenix Heart PLLC

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Patient information

For:
Date of Birth:
MRN:

I_____
(Please print the name of the person completing this form)
Authorize:_____
(Please print the name of clinic, hospital or individual)
To disclose the following medical treatment information
To:_____
(Please print the name of clinic, hospital or individual)
For care provided to (Patient Name): _____
On these dates:_____

The information released will be used for the following purpose:
_____

I specifically authorize the release of the following:

___Entire record
___Drug/Alcohol Abuse Treatment
___Human Immunodeficiency Virus (H.I.V.) Antibody Test, Results, and Treatment Information
___X-Ray Report
___Lab Report
___Only those items listed below:
___Psychiatric and Mental Illness Treatment
___Registration Record
___History and Physical
___Operative Report
___EKG Report
___Visit/Encounter Notes

___Other:_____

I expressly and voluntarily authorize disclosure of the above medical record for the purposes stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization. This release is effective for 90 days from the date signed, unless otherwise specified as follows:
_____

I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

_____ _____
Signature of Patient/Date SSN, Date of Birth, and Other Names Used

_____
Parent, Guardian, or Legal Representative/Date (State Your Relationship to the Patient)