Phoenix Heart PLLC

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Patient information

For:
Date of Birth:
MRN:

(Optional) Release of Information (ROI) to Other Individual(s)

This authorization grants permission to the person named below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis and treatment plans; and have access to my financial health information.

MRN # (staff use): _____

Authorized Individual: _____

Relationship to patient: _____Telephone:_____

Authorized Individual: _____

Relationship to patient: _____Telephone:_____

Authorized Individual: _____
Relationship to patient: _____Telephone:_____

I hereby authorize Phoenix Heart, PLLC to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to the party named above the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying Phoenix Heart, PLLC in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Phoenix Heart, PLLC prior to their receipt of the revocation.

I understand that my treatment cannot be conditioned on whether I sign this authorization.

Patient Signature: _____

Date: _____