5859 W Talavi Blvd, Suite 100, Glendale, AZ 85306 Phone: 602-298-7777 Fax: 623-930-6060
www.phoenixheart.com

Patient information For:
Date of Birth:
MRN:

I hereby authorize **Phoenix Heart, PLLC,** its medical staff, employees and their representatives to

RELEASE or **REQUEST**
(circle one)

my protected health information to or from the following individual or entity:

Name:____

Address:______________________________________City:_______________ State:____ Zip:______

Phone:__________________ Fax (Dr. Offices ONLY):__________________

Send by: (choose one) ____ Mail

____ Pick up at ____________ office. (ID Required)

____ Fax/Secure Email (**this option is ONLY available to select Providers**)

Please send:

___ All Records

___ Specific Item(s) Only (please list)____

For the following dates of service:

From (MM/DD/YYYY): _____/_____/_______ to _____/_____/_______

Purpose for Disclosure: (check all applicable):

___Treatment/Coordination of Care ___Establish with New Provider

___Other (Please specify):____

I expressly and voluntarily authorize disclosure of the above medical record for the purposes stated above. This authorization will not expire except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that I have the right to revoke with authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written request to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to receive a copy of this authorization.

______________________________ ____/____/______
Signature of Patient/Guardian/POA Date

______________________________ ______________________________
Printed Name Relationship to Patient if Applicable