



ACCREDITED CARDIOLOGY OF ARIZONA

3303 East Baseline Rd. Ste 203 , Gilbert, AZ 85234
480.968.7600 FAX 480.968.8003

Authorization to Release Records

Patient Name (please print)

DOB

Phone (Day)

Phone (Evening)

The above individual requests that a copy of any and all his (or her) medical records be released and forwarded to our office at the address shown above.

Please forward All Records Progress Notes Lab

: Tests/EKG Other (please specify) _____

Please Direct records:

From To

Medical Records Department
Accredited Cardiology LLC
3303 East Baseline Rd.
St 203
Gilbert, AZ 85234

From To

Name
Address
Phone

I hereby authorize the release of copies of medical records, in written form only, including those which contain confidential HIV/AIDS related information (as defined in A.R.S Section 36-661), confidential communicable disease related information (as defined in A.R.S. Section 36-661), and information relating to mental health and/or alcohol/drug use. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically six months from the date on which it is signed. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purpose of the disclosure.

3. _____ When initialed, this paragraph authorizes the transmission of my medical information via TELEFAX machine to _____. This request is only used when the information is to be used for emergency medical patient care, not in the routine release of data which may be served as effectively by mail or messenger.

Patient's Signature

Date

Witness Signature

Relationship to Patient

For Office Use Only

Faxed

Mailed

By _____

Date _____