ADVANCED
CARDIOVASCULAR
CENTER

Authorization to release protected health information

Patient Information

Last Name:.. First Name: .... MI:..................................

Street Address: .... City: .... ST:................ ZIP:.....................

Home Phone:..................................... Cell Phone:.............................. Work Phone:.....................................

Date of Birth:............................ Gender: ☐ Male ☐ Female SSN:.................. Account#:...........................

Email Address:...

I hereby consent and authorize to release of medical record information concerning the above-mentioned patient.

FROM:

Name of Facility to Release the Information:... Phone: ....

Street Address:.. City:....................................

ST:............................ ZIP:............................

TO:

Advanced Cardiovascular Center
13481 W McDowell Road
Suite 400, Goodyear, AZ 85395
Ph: 623-335-3044, Fax: 623-335-3054

☐ Pick up records at Advanced Cardiovascular Center (address above)

☐ Mail to the facility stated above

Records not picked up within 30 days will be mailed to the facility stated above.

Purpose of Release:

Appointment /Continuation of Care Personal Use

Information to be Released:

☐ Consultation(s) ☐ Echocardiogram Report ☐ All Cardiology Records ☐ Office Note(s) ☐ Treadmill

☐ Event Monitor ☐ EKG(s) ☐ Holter Monitor ☐ Laboratory Test(s)

Other - Please specify ....

Date of service from .... to ....

(The last two years of non-cardiology treatment will be released if no dates of service are identified.)

I authorize the release of photocopies of the following medical records and/or videotapes in the possession or control of Advanced Cardiovascular Center, its employees, and/or agents.

FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "VIDEOTAPES" SHALL INCLUDE ALL:

(1) CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661).

(2) CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661).

(3) CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ).

(4) CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

(5) CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801).

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for the release of medical information. This consent will expire ninety (90) days after the signed date below. I have given my consent freely, voluntarily, and without coercion. I have the right to inspect and copy the information being requested for use or disclosure. I can refuse to sign the authorization without retaliation. I understand that information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA's privacy rule protections. I may revoke this authorization at any time providing I notify Advanced Cardiovascular Center in writing to that effect. I understand that any releases, which are not 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/facsimile of this authorization is considered acceptable in lieu of the original.

Date: **Signature:**