ADVANCED CARDIOVASCULAR CENTER

Authorization to Release Medical Records to Advanced Cardiovascular Center

I hereby authorize ..... (Healthcare Provider Name), located at .....

(Address or Fax) to release my Medical Records to Advanced Cardiovascular Center

Patient Name: ..... Phone Number: .....

Address: .....

Street ..... City.....State.....Zip Code.....

Date of birth: ..... Date of request: .....

Medical Records are to be sent to: Advanced Cardiovascular Center
13481 W McDowell Road
Suite 400, Goodyear, AZ 85395
Ph: 623-335-3044, Fax: 623-335-3054

Please check and complete all that apply.

- ☐ Medical Records for Date(s) of:
- ☐ Imaging and Area for Date(s) of:
- ☐ Other, please be specific:

Health Information is to be disclosed for the following purpose: (check all that apply)

- ☐ Change in Insurance or Healthcare Provider
- ☐ Continuation of Care

I understand that this information shall be in effect for 180 days following the date of signature. further, I may revoke this authorization at any time by giving oral or written notice to ACC. A photocopy of this authorization shall constitute a valid authorization. I realize once my medical records have been released to ACC, my revocation cannot be effective to the extent that the healthcare provider has taken the action and with the reliance of this Authorization.

I understand that the health information I am authorizing may disclose additional information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis, or treatment for HU, HI\/-related diseases, and communicable disease-related information.

I understand that ACC may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I have read this Authorization and I acknowledge being familiar and fully understand its terms and conditions.

Patient Name (please print):

Relationship to Patient: **Date:** **Signature:**