CARDIOVASCULAR CONSULTANTS, LTD.

Authorization to Release Protected Health Information

(Medical Records Release)

Patient Name: _____ **Date of Birth:** _____

Social Security #: _____ **Phone:** _____ **Acct. #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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

* **FROM:** (Required)

_____
NAME (Facility to release the information)

_____
(Address)

_____
(City, State, Zip)

MAIL TO: **-or-** **FAX TO:**

CVC Medical Records
3805 E. Bell Rd., Suite 3100
Phoenix, AZ 85032

602.824.9540

Questions or Concerns:
602.795.5984

Purpose of the Release

- ☐ Appointment/Continuation of Care
- ☐ Personal Use
- ☐ Pick up at _____
  Cardiovascular Consultants Clinic Location

_____
Records not picked up within 30 days will be mailed to the address above.

Information to be Released

- ☐ Consultation(s)
- ☐ Office Note(s)
- ☐ Event Monitor
- ☐ Holter Monitor
- ☐ Other - please specify _____
- ☐ Echocardiogram report
- ☐ Treadmill
- ☐ EKG(s)
- ☐ Laboratory test(s)
- ☐ All Cardiology Records

Dates 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 photocopied of the following medical records and/or videotapes in the posession or control of Cardiovascular Consultants, 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 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 HIPPA's privacy rule protections. I may revoke this authorization at any time providing I notify Cardiovascular Consultants 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 consititute a breach of my rights to confidentiality. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original.

_____
* **Patient Signature** (Required)

* **Date** (Required)

Records prepared and transmitted by:

_____
Signature of CVC Representative

Date

* **Required**