Patient name: _____

Date of Birth (MM/DD/YYYY): ____/____/_____

Patient ID (if available): _____

Phoenix
Heart | Vein | Vascular

Consent for Release of Information

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:

This form is being requested by: Facility/provider or patient (circle one)

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 only available to select providers)

Please send:
_____ All Records
_____ Specific Item(s) Only (please list):_____

For the following dates of services: 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 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 _____

Printed Name _____ Date ____/____/_____

Relationship to Patient (if applicable) _____

PHONE: (602) 298-7777
FAX: (623) 930-6060
MEDICALRECORDS@PHOENIXHEART.COM