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: [ ] M [ ] F SSN: _____ Account #: _____

Email Address: _____

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

FROM:

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

Street Address: _____ City: _____ ST: _____ ZIP: _____

TO:

Peak Heart and Vascular
12361 W Bola Dr, Ste 100
Surprise, AZ 85378

Fax: 480-500-8430
Phone: 602-641-9486

[ ] Pick up records at Peak Heart and Vascular (address above)
[ ] Mail to facility stated above

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

Peak
Heart & Vascular

Purpose of the 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 _____

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 possession or control of Peak Heart and Vascular, 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 HIPAA's privacy rule protections. I may revoke this authorization at any time providing I notify Peak Heart and Vascular 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.

Signature: _____ Date: _____