Release of Medical Records Authorization

Please print and fill in all blanks

Patient Name: ____________________________ SSN: _______________

Address: _________________________________ DOB: ______________

City: _____________ State: _________ Zip: _________ Phone: ___________

Information Requested:

_______ ENTIRE RECORD (includes all of the following)
_______ Office Visit Notes **_______ EKG**
_______ Mental Health Treatment **_______ Cardiac Testing**
_______ Laboratory Results **_______ HIV/AIDS/STD Treatment**
_______ X Ray and Imaging Reports **_______ Operative Reports**
_______ Other ____

Records dates From: ___/___/______ To: ___/___/______

I prefer: _____ Photocopies _____ Electronic copies

- **Furnish records TO A Cardiac Arrhythmia Institute**
- **Release records FROM A Cardiac Arrhythmia Institute**

Name: ____

Address: ____

City: ________________ State: ______ Zip: ________ Phone/Fax (circle one): ____________

I authorize the release of photocopies, faxed copies or electronic copies of the following medical records. For the purpose hereof, "Medical Records" shall include:
All confidential HIV-related information, confidential communicable disease-related information (as defined in A.R.S. Section 36-661), confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 et. Seq.) and confidential mental health diagnosis and treatment information.

Signature Authorizing Release of records: ______________________ Date: ___________

Record Pick Up Information: Signature: ______________________ Date: ___________

Photo ID#: ____________________

This authorization is valid for this request only

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