Consent and Authorization for Disclosure and Release of Medical Records

This form is used to request the release of Medical Records from East Valley Cardiology, LTD. (EVC)

Patient Name: _____ Phone Number: _____

Address: _____
Street City State Zip Code

Date of birth: _____ Date of request: _____

Physician or Name of Authorized Person(s) to receive medical records:
_____
Address: _____
Contact Phone Number: _____
Fax Number: _____

Please check and complete all that apply:

All Medical Records
Medical Records with Specific Date(s)_____
Imaging and Area for Date(s) of: _____
Other, please be specific: _____

Choose one method for receiving medical records:

Pick up at clinic location.
Mail to: _____
Fax to: _____

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may be revoke this authorization at any time by giving oral or written notice to EVC. A photocopy of this authorization shall constitute a valid authorization. I realize once my medical records have been released, EVC cannot retrieve them and has no control over the use of the already released copies. 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 HIV, HIV-related diseases and communicable disease-related information.

There may be fees associated in providing copies of medical records. ***Initial_____.***

Please Note:
The attached medical information pertaining to the above mentioned patient is confidential and legally privileged. EVC has provided it to the above noted recipient as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law. I hereby release EVC from any and all liability which may arise as a result of my authorized release of records. I understand that EVC, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I have read this authorization and acknowledge the terms and conditions.

Print Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

(*Attach copy of documentation authorized as patient legal representative.)

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the patient to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.

Reference Number 11.02