Authorization to Release Medical Records to East Valley Cardiology, LTD.

I hereby authorize _____, located at_____,
Healthcare Provider Name *Address or Fax*

to release my Medical Records to East Valley Cardiology, LTD.

Patient's Name: _____Phone number: _____

Address: _____
Street City State Zip Code

Date of birth: _____ Date of request: _____

Medical Records are to be sent to: EAST VALLEY CARDIOLOGY
595 N. Dobson Rd. Ste. C-48
Chandler, AZ. 85224
Fax: (480)899-9554
ATTN: MEDICAL RECORDS

Please check and complete all that apply.

- ☐ Medical Records for Date(s) of: _____
- ☐ Imaging and Area for Date(s) of: _____
- ☐ Other, please be specific: _____

Health Information to be disclosed for the following purpose: (check all that apply)

- ☐ *Change in Insurance or Healthcare Provider*
- ☐ *Continuation of Care*

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may 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 to EVC, my revocation cannot be effective to the extent which the healthcare provider has taken the action and with the reliance of this Authorization.

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.

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 I acknowledge being familiar and fully understand its terms and conditions.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed name or Personal Representative / Relationship Telephone Number