9520 W Palm Ln Ste 150-A Phx, Az 85037 P:602-584-5444 F:602-584-6202

Medical Records Release Form

I do hereby consent and authorize Heart One Associates Physicians to release copies of my medical records.

Patient Name: _____ Next Appt:_____
Date of Birth_____SSN (**last 4 for The VA only**): _____
Address:_____
City, State and Zip Code:_____Home Phone:_____

Information to be released from:
Name of Person or Facility: _____
Practice Address: _____
City, State and Zip Code_____
Phone: _____Fax: _____

Information to be released to:
Name of Person or Facility: _____
Practice Address: _____
City, State and Zip Code_____
Phone: _____Fax: _____

Please select all specific document that apply to request:

__ Pertinent Information (Please include most recent Office Visits, ECG, Labs & Cardiac Testing)
__ All Cardiac Records
__ Specific Information (Please specify) _____

Please select the purpose of your request:
__ Continued Patient Care __ Attorney/Legal __ Insurance __ Social Service/Disability
__Worker's Compensation __ Personal __ Other_____

I understand that my recorders are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke the authorization in writing at any time except to extent that action has been taken in reliance upon the authorization.

Signature:_____**Date:**_____/_____/_____

Patient or Legally Authorized Representative / Release Completed By (Date/Initials):_____/_____/___/_____