

Heart & Vascular Center



of Arizona

Noninvasive, Invasive and
Interventional Cardiology,
Peripheral Vascular Disease
Electrophysiology and
Women's Cardiology

AUTHORIZATION TO RELEASE MEDICAL RECORDS

NATHAN LAUFER, MD, FACC
Medical Director

E.C. BARRETO, MD
In Memoriam

ASHISH PERSHAD, MD, FACC
ADAM BRODSKY, MD, FACC
PARMINDER SINGH, MD, FACC
SUZANNE SOROF, MD, FACC
AMIT SRIVASTAVA, MD
Interventional Cardiology

ALAN GROSSMAN, MD, FACC
Noninvasive Cardiology

ASHISH SADHU, MD
Electrophysiology

JANET WALTERS, RN, MSN, ANP
JANET FETT, RN, MS, ACNP
C. KAY ZIMMERMAN, MSN, ANP, CDE
MARY JO STUCKY-HEIL, RN, MSN, APR
LORI KLASKI, BS, PA-C
WEI-JEN SHEU, RN, MSN, ACNP
BETHANIE SORENSEN, BS, PA-C

BARBARA WATKINS, RN
Administrator

MARILYN PEREZ
Human Resources Administrator

1331 N. 7th Street, Suite 375
Phoenix, Arizona 85006

9305 E. Thomas Road, Suite 270
Phoenix, Arizona 85037

20940 N. Tatum Blvd., Suite 325
Phoenix, Arizona 85050

Phone: 602-307-0070
FAX: 602-307-0080

www.heartcenteraz.com



Nuclear Cardiology
Accredited Nuclear
Cardiology Laboratory

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____-____-____

Home Phone #: (____)____-____ Work Phone #: (____)____-____

I hereby authorize _____ to send/release photocopies of medical records concerning the above named patient to:

Heart and Vascular Center of Arizona
1331 North 7th Street, Suite 375
Phoenix, Arizona 85006

For the purpose of: _____ I authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of _____ its employees and/or agents. FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-611), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.) AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

_____ Medical Records
_____ Hospital Records of _____ (IP) (OP)
_____ Electrocardiograms
_____ Laboratory Reports
_____ Other _____

This consent will expire sixty (60) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify my health plan in writing to that effect. I understand that any release which was 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 of this authorization is considered acceptable in lieu of the original.

Patient Signature

Date

Parent/Legally Authorized Representative

Relationship To Patient