

**PHOENIX HEART PLLC**

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Avondale, Arizona 85323

**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security: \_\_\_\_\_ (optional)

I request and authorize PHOENIX HEART PLLC to release health care information of the patient named above to:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

This request and authorization applies to:

Health care information relating to the following treatment, conditions, dates \_\_\_\_\_

All Health care information

Other \_\_\_\_\_

**Please be advised:** Any health care record can contain personal and/or private information you may not want divulged such as STD results (sexually transmitted disease). HIV/AIDS testing, whether negative or positive, requires a separate form. This information may be directly generated by Phoenix Heart doctors as part of your care or it may be indirectly generated by requesting records from other treating doctors. All medical, information contained in a patients chart is necessary for complete and accurate treatment of your condition and will be released to the person(s) named above unless it is specifically stated only certain information may be releases.

YES NO I grant permission to leave test results or messages on my answering machine at home, at work , other number \_\_\_\_\_

YES NO I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above

Patient Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

I understand information will be released to only the person listed above.

**THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.**