AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Tri-City Cardiology Consultants, P.C.

6343 E. Main Street, Suite 12, Mesa AZ 85205 Phone (480) 835-6100 Fax (480) 461-4243

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____Cell Phone: _____

___I hereby authorize Tri-City Cardiology to RECEIVE medical records FROM:

___I hereby authorize Tri-City Cardiology to RELEASE medical records TO: (*$25 Fee applies if personal copy >10 pages)*

Physician/Provider/Patient Name: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records Needed for: ☐ Physician Appt on: _____ ☐Personal Copy ☐ Other: _____
Date

List Specific Medical Records requested:

_____

I hereby authorize the release of photocopies of the following medical records. **Please initial all that apply.**

For the purpose hereof, "medical records" shall include all:

___ 1. Confidential HIV-related information (as defined in A.R.S section 36-6610)

___ 2. Confidential communicable disease-related information (as defined in A.R.S. section 36-6610)

___ 3. Confidential alcohol or drug abuse-related information (as defined in 42 CFR section 2.1 ET SEQ)

___ 4. Confidential mental health diagnosis/treatment information

___ 5. Confidential genetic testing information (as defined in A.R.S section 12-2801)

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. This consent will expire ninety (90) days after signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Tri-City Cardiology Consultants, P.C. in writing to that effect. I understand that any releases which were not made prior to my revocation in compliance with this authorization shall constitute a breach of my rights to confidentiality. I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original. Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

IMPORTANT INFORMATION/NOTICES FOR THE RECIPIENT:

The attached photocopies of medical records are requested from you pursuant to the authorization and request the patient specified above on this consent submitted to Tri-City Cardiology Consultants, P.C. If you received any medical records and/or x-ray films which included confidential HIV or communicable disease related information as defined in A.R.S. Section 36-661, the following notice on re-disclosure applies under Arizona law:

This information has been disclosed to you from confidential records which are protected by state law that prohibits further re-disclosure of the information without the specific written consent of the person to whom it pertains or as otherwise permitted by law, A.R.S. Section 36-664 (G). If you received any medical records and/or x-ray films which included confidential alcohol or drug abuse-related information as defined in 42 CFR Section 2.1 et seg. the following notice on re-disclosure applies under the federal law. **This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR PART II). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR PART II. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

THIS FORM MUST BE COMPLETELY FILLED OUT TO PROCESS. PLEASE ALLOW 7-10 BUSINESS DAYS

PATIENT SIGNATURE: _____DATE: _____

PARENT/GUARDIAN/POA SIGNATURE: _____DATE:_____

RECORDS PREPARED AND TRANSMITTED/MAILED BY: _____

Updated 2.26.24