LAS SENDAS CARDIOLOGY

3514 N. Power Rd. Suite #107 Mesa, AZ 85215 P: 480-361-9949 F: 480-361-9969

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

PHONE #: _____ EMAIL: _____

I HEREBY GIVE AUTHORIZATION TO:

NAME: _____

ADDRESS: _____

TO RELEASE THE FOLLOWING INFORMATION CONCERNING MYSELF TO:

LAS SENDAS CARDIOLOGY 3514 N. POWER RD. STE. 107, MESA, AZ 85215 P: 480-361-9949 **F: 480-361-9969**

PLEASE GIVE COPIES OF THE FOLLOWING REQUESTED INFORMATION.

I UNDERSTAND THAT MY EXPRESSED CONSENT IS REQUIRED TO RELEASE ANY HEALTH CARE INFORMATION RELATING TO TESTING, DIAGNOSIS, AND TREATMENT FOR HIV (AIDS), SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC DISORDERS/MENTAL HEALTH, OR DRUG AND/OR ALCOHOL USE. YOU ARE SPECIFICALLY AUTHORIZED TO RELEASE ALL HEALTH CARE INFORMATION RELATING TO SUCH DIAGNOSIS, TESTING, OR TREATMENT.

_____ _____

SIGNATURE OF PATIENT DATE