LAS SENDAS CARDIOLOGY

3514 N. POWER RD. #107 MESA, AZ 85215 PH 480-361-9949 FAX 480-361-9969

AUTHORIZATION TO RELEASE AND RECEIVE MEDICAL INFORMATION

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

PHONE #: _____ EMAIL: _____

I HEREBY GIVE AUTHORIZATION TO:

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

TO RELEASE THE FOLLOWING INFORMATION CONCERNING MYSELF TO:

NAME:

ADDRESS:

PHONE NUMBER:

FAX NUMBER:

PLEASE ALLOW 10 WORKING BUSINESS DAYS FOR TRANSMISSION OF THE ABOVE REQUEST.

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