

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth _____

Address _____ Social Security# _____

Phone (Day) _____ Phone (Evening) _____

I hereby authorize _____
NAME OF COMPANY

ADDRESS STATE ZIP

To send/release copies of medical records concerning the above named patients to:

Heart Arteries and Veins
Walid Alami, M.D.
9445 E. Ironwood Square Drive Suite # 110
Scottsdale, AZ 85258
Phone: 480-747-6532 Fax:480-889-6865

I hereby authorize the release of copies of any or all medical and or/x-ray films that are in your possession. For the purpose 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 36-661) confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 ET SEQ.), confidential mental health diagnosis/treatment information, and confidential genetics testing information (as defined in A.R.S. section 12-2801).

Information to be sent: All Records
 Other: _____

I understand that this authorization shall expire, without my express revocation, six months from the date written below. I understand that a photocopy of this authorization is considered acceptable in Lieu of the original.

PATIENT'S SIGNATURE

DATE

PARENT/LEGALLY AUTHORIZED REPRESENTATIVE

DATE

