San Tan CARDIOVASCULAR CENTER

6859 E Rembrandt Ave – Suite 117 – Mesa, AZ 85212

6740 S Kings Ranch Rd – Suite 103 – Gold Canyon, AZ 85118

3980 E Riggs Rd – Bldg 4 Suite 2 – Chandler, AZ 85249

REQUEST OF PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____

Phone: _____ Email Address: _____

I hereby authorize San Tan Cardiovascular Center

To **REQUEST** my medical records **FROM:**

Physician / Entity Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Fax: _____

IF MORE THAN 20 PAGES DO NOT FAX, PLEASE MAIL or

EMAIL to our secure address: santancvma@santancvmedrec.com

By signing below, I authorize the release of medical records, including but not limited to, HIV related information, communicable disease, alcohol abuse, drug abuse, mental health, and genetic testing information. This consent will expire 90 days from date signed. I can revoke this authorization at any time by notifying San Tan Cardiovascular Center in writing. I understand that a photocopy or facsimile of this authorization is acceptable in lieu of the original.

This information has been disclosed to the recipient above from confidential records which are protected by state law that prohibits further re-disclosure of the information without specific written consent from the patient listed above. (A.R.S. Section 36-664 (G).

Signature: _____ Date: _____

Printed Name: _____