FORM 6, AUTHORIZATION TO RECEIVE HEALTH INFORMATION
Tri-City Cardiology Consultants, P.C.

_____ 6750 East Baywood Ave., Suite 301, Mesa AZ 85206 Phone (480) 835-6100 Fax (480) 461-4243

_____ 1520 South Dobson Rd., Suite 209, Mesa AZ 85202 Phone (480) 835-6100 Fax (480) 461-4243

_____ 2680 S. Val Vista Dr., Building 15, Suite 185, Gilbert AZ 85295 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 the Physician/Provider below:

Physician/Provider Name _____

Address _____City _____ State _____ Zip _____

Phone _____ Fax _____

I hereby authorize the release of photocopies of the following medical records. 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.

Medical Records Requested (check one)

_____ ALL Records _____ Past Two Years _____ Testing _____ Specific _____ Pertinent Information (recent)

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-related information or confidential 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

PATIENT SIGNATURE _____ DATE _____

PARENT/GUARDIAN/POA SIGNATURE _____ DATE _____

RECORDS PREPARED AND TRANSMITTED/MAILED BY _____

Rev 11/10

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Patient Name _____ Date of Birth _____

Address _____

Home Phone _____Cell Phone _____

_____ I hereby authorize the RELEASE of photocopies of the following medical records to:

Physician/Provider/Patient Name _____

Address _____City _____ State _____ Zip _____

Phone _____ Fax _____

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Medical Records Requested (check one)

_____ ALL Records _____ Past Two Years _____ Testing _____ Specific _____ Pertinent Information (recent)

IMPORTANT INFORMATION/NOTICES FOR THE RECIPIENT:

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