Southwest CVA
Cardiovascular Associates

Medical Records Release Authorization

Patient Name:_____ **Birth Date:**_____

Address:_____ **Phone:**_____

I authorize the release of records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease related information, information relating to mental health and/or alcohol/drug use, from the following facilities:

_____

_____

_____

Please Send the Following Records *(check all that apply)*

- ☐ **All pertinent reports**
- ☐ **Consultation**
- ☐ **Discharge Summary**
- ☐ **EKG Reports**
- ☐ **History & Physical**
- ☐ **Lab Reports**
- ☐ **Operative Report**
- ☐ **Pathology Report**
- ☐ **X-Ray Reports**
- ☐ **Other: Specify**_____

How would you like your Medical Records? *(check one)*

- ☐ **Faxed** *(free, no charge)*
- ☐ **E-Mail** *(free, no charge)*
- ☐ **Copied on my Flash Drive** *(free, no charge)*
- ☐ **Pick-up in Office** *(10¢ per pg + admin fee)*
- ☐ **U.S. Mail** *(10¢ per pg, postage + admin fee)*

I hereby authorize: Southwest Cardiovascular Associates to release all of the above requested information relative to my treatment and care to:

_____
(Name of Doctor, Facility or Person Receiving Records)

_____
(Address, City, State, Zip)

_____ _____ _____
(Phone) *(Fax)* *(E-mail)*
may not be secure

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically six months from the date on which it is signed. Any disclosure of medical record information by the recipient(s) is not authorized except when implicit in the purposes of the disclosure.

_____ _____
***Patient Signature** **Date**

_____
***Signature of Other Authorized Person**

_____
***Relationship to Patient**

If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and parent or legal guardian must sign.

☐ *I affirm that the patient is deceased, that no personal representative of his estate has been appointed,*

and that I am the patient's: _____.
(Relationship to Patient)

_____ _____
Signature of Representative *Date*

Southwest Cardiovascular Associates
140 South Power Road
Mesa, Arizona 85206-5297
480-945-4343 *phone* **480-945-4350** *fax*
www.swcva.com