ATRIA HEART
CARDIAC CLINIC & WELLNESS CENTER

16427 N. SCOTTSDALE ROAD, STE. 100
SCOTTSDALE, AZ 85254-8197
(480) 718-5072 • FAX: (480) 718-5074

AUTHORIZATION TO RELEASE MEDICAL RECORDS

As required by the Health Information Portability and Accountability Act of 1996 and Arizona law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information complied in reasonable participation of, or for use in , a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

to release healthcare information of the patient named above to:

Name: **Atria Heart, PLLC (Maulik G. Shah, M.D. / Wesley A. Tyree, M.D.)**

Address: **16427 N. Scottsdale Road, Ste. 100**

City: **Scottsdale** State: **AZ** Zip Code: **85254-8197**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

_____

☐ Other: _____

I understand and hereby also consent to the release of any and all alcohol and/ or drug abuse information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or psychiatric treatment records under the same conditions outlined below. I understand that such informatio0n cannot be release without my specific consent.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED