VASCULAR HEART & LUNG ASSOCIATES
Hani Shennib, MD, MSc, FRCSC, FACS / Richard R. Heuser, MD, FACC, FACP, FESC, MSCAI / Katie Harjes, NP
3850 E Baseline Road, Building 1, Suite 103 • Mesa, AZ 85206
Phone: 480 722 7589 • Fax 480 857 8313

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please provide complete and accurate information when submitting this form. Please allow 7-10 business days.

First Name:	Last Name:		
Date of Birth:	Social Security Number:		
Address:	City:	State:	Zip:
Home Telephone:	Cell:		

I AUTHORIZE RELEASE OF PERSONAL HEALTH INFORMATION CONCERNING: (Please check one of the following.)

☐ All medical records.
☐ Treatment of (please identify condition): ____________________
☐ Treatment received on the following date(s): ____________________
☐ Other (please describe*):* ____________________

I understand the authorization includes consent for, if applicable, the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted disease, HIV testing, AIDS and any AIDS related syndromes. It also includes any information concerning cancer, cancer testing and cancer results.

Records needed for: ☐ Dr. Appt On: __________ ☐ Personal Copy ☐ Other: ____________________

RELEASE: I authorize **Vascular, Heart and Lung Associates** to release my personal health care information to**:**
Name: ____________________
Address: ____________________
Telephone Number: ____________________ Fax Number: ____________________

REQUEST:
I authorize (name of doctor or facility): ____________________
Address, City, State and Zip Code: ____________________
Telephone Number: ____________________ Fax Number: ____________________
to release my private health information as identified above to:

Vascular, Heart and Lung Associates
Hani Shennib, MD / Richard Heuser, MD / Katie Harjes, NP
3850 E Baseline Rd, Suite 103
Mesa, AZ 85206
FAX NUMBER: 480-857-8313

I understand that I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to the releasing provider. I understand that once information is used or disclosed based on this authorization it may be re-disclosed by the recipient and at such time may no longer be protected by federal privacy laws or regulations.

I hereby consent and authorize you to release copies of my personal health information, including current and previous medical records from other practices and practitioners, hospitals and/or clinics, which are part of my medical records. I agree that a copy of this release or a fax of this release shall be valid as the original release.

Patient Signature (or patient representative)	Date:

If signed by a patient representative, please provide a description of the representative's authority to sign on behalf of the patient: ____________________.