Phoenician Cardiac Care
Phone: (480) 444-7464 Fax: (480) 912-7922
2075 W Pecos Rd #B1 Chandler, AZ 85224
2226 W Northern Ave D-270 Phoenix, AZ 85021
www.phoeniciancardiaccare.com

Date: _____

Patient's name: _____ DOB: _____

Address: _____

City: _____state: _____ _____ zip: _____

SSN: _____ Daytime phone # (_____) _____

Are you transferring out of our facility? ☐ Yes ☐ No

If yes, reason for leaving practice?_____

_____

☐ **OBTAIN** my records from ☐ **RELEASE** my records to

(If releasing records to self, charges will apply)

Facility name: _____

Provider's name: _____

Address: _____

City: _____ State: _____Zip Code:_____

Phone (_____)_____-_____ fax (_____) _____ ___ -_____

I hereby consent to the release of all, medical records and other documentation pertaining to the medical care received in this facility, including the following:

☐ All treatment*

☐ Lab reports/x-ray reports

☐ Treatment related to specific injury or illness_____

☐ Beginning and ending date of treatment _____to _____

I understand that I am only obtaining the records produced by this facility and not the records that were forwarded from any previous primary care physicians, etc. I specifically consent to the release of any info contained in the medical records, which may relate to the infection with human immunodeficiency virus (HIV), ads or related conditions, as well as information regarded as confidential.

I understand that Phoenician Cardiac Care has no responsibility for the use or distribution of this information by the party to whom it is released. I release Phoenician Cardiac Care from all liability which could arise from the compliance with this request to release records. I authorize Phoenician Cardiac Care to transmit this information by facsimile transmission (fax) and/or mail and release Phoenician Cardiac Care from any liability for potential breach of confidentiality due to misdirection of transmission or failure to receive transmission of my records.

Patient signature: _____ Date: _____