



**NORTH PHOENIX HEART CENTER**  
THE VALLEY'S PREMIERE CARDIOLOGY GROUP

Physician /Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

- All my health information including, but not limited to, AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and/or drug abuse treatment, if any, unless specifically excepted: \_\_\_\_\_
- My health information relating to the following treatment or condition: \_\_\_\_\_
- My health information for the date(s): \_\_\_\_\_
- All psychotherapy notes unless specifically excepted: \_\_\_\_\_
- Other: \_\_\_\_\_

**Send all records to:**

**North Phoenix Heart Center**  
**Attn: Medical Records**  
**9250 N. 3<sup>rd</sup> St., Ste 3010**  
**Phoenix, AZ 85020**  
**(602) 218-7167**  
**FAX: (602) 678-6700**

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months from the date signed. *North Phoenix Heart Center, P.C.*, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: \_\_\_\_\_  
Signature of Patient/Legal Representative/Responsible Party Date

\_\_\_\_\_  
Signature of Witness Date