MEDICAL RECORDS RELEASE FORM

UPDATED 9.1.2020

PATIENT NAME:____**DATE OF BIRTH:**____________________

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the clinician, person, facility, and/or entity listed below.

THE INFORMATION YOU MAY RELEASE SUBJECT TO THIS SIGNED RELEASE FORM IS AS FOLLOWS:

○ Complete Record(s)	○ Progress Note(s) - 3 most recent	○ Radiology Report(s)
○ Pathology Report(s)	○ Lab Report(s)	○ Operative Report(s)
○ Hospital Report (s)	○ Treatment Record(s)	○ Coronary Angiogram(s)
○ Vascular Report (s)	○ Medication Record(s)	○ Peripheral Angiogram(s)
○ History & Physical	○ Ultrasound Report(s)	○ Other (specified below)

Other: ____
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Please release my protected health information to the following clinician, person, facility, and/or entity listed below:

Ponderosa Heart House Call
Address: 115 S. Alto St., Suite 3
Prescott, AZ 86303
Phone: (480) 795-1515
Fax: (480) 597-1723

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PATIENT/PATIENT REPRESENTATIVE SIGNATURE **PATIENT/ PATIENT REPRESENTATIVE PRINTED NAME**

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DATE