Valley Heart Associates
KLEE • STEVENSON • DALLOUL

Request for Release of Medical Records

I authorize the release of the following medical record photocopies and/or x-ray film copies, ***to or from*** the facility/facilities referenced below (to include the named facility, its employees and/or agents):

FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION and/or CONFIDENTIAL COMMUNICABLE DISEASES-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 **ET SEQ**.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

Get Records FROM:	**Send Records TO:**
RECORDS REQUESTED:	

Valley Heart Associates
2075 West Pecos Road
Suite 1
Phone: (480) 656-5711
Fax: (480) 656-5622

Patient's Signature: _____

Patient's Name: _____

Patient's DOB: _____