ARIZONA HEART 360, P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ DOB:_____

Patient Address: _____
ADDRESS CITY, STATE ZIP CODE

Patient Phone:_____

RECORDS REQUESTED FROM/TO:

Name of Person or Facility: _____

Address: _____

Email Address: _____

Phone:_____ Fax:_____

RECORDS NEEDED (OFFICE USE ONLY)

- CLINICAL/PROGRESS NOTES
- HISTORY & PHYSICAL
- CARDIAC RADIOLOGY REPORTS
- LAB REPORTS
- EKG
- OTHER: _____

I authorize for my records to be released from/to Dr. Sarika Desai, D.O. / Arizona Heart 360, P.C.

Signature: _____ Date: _____