

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

**I authorize** Western Vascular Institute Phone # 480-668-5000  
Address: 6750 East Baywood Ave. Ste 506 Fax # 480-668-5065  
City, State , Zip: Mesa, AZ 85206

**To release health/medical information of:**

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This information is to be released to:

**I authorize** \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_ Fax # \_\_\_\_\_  
City, State , Zip: \_\_\_\_\_

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually-transmitted diseases, etc., unless herein excepted:

\_\_\_\_\_

This release includes specifically:

Office Notes: \_\_\_\_\_ Laboratory Reports: \_\_\_\_\_  
Complete Record: \_\_\_\_\_ Radiology Reports: \_\_\_\_\_  
History & Physical: \_\_\_\_\_ EKG: \_\_\_\_\_  
Other: \_\_\_\_\_

Covering records from:

- 1) the period from: \_\_\_\_\_ to \_\_\_\_\_
- 2) date of service: \_\_\_\_\_

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 IN SIX MONTHS FROM THE DATE SIGNED, OR UNTIL THE FOLLOWING EVENT OR CONDITION:

\_\_\_\_\_

SIGNATURE (person authorizing release): \_\_\_\_\_

Date of Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_