6116 E Arbor Ave Bldg 3, Ste 112, Mesa, AZ 85206
2730 S Val Vista Dr. Bldg 8N, Ste 140, Gilbert, AZ 85295
2979 W Elliot Rd. Bldg 5, Ste 112, Chandler, AZ 85224
37100 N Gantzel Rd, Ste 202, Queen Creek, AZ 85140
P (480) 641-5400 F (480) 218-4353

Release of Information (ROI) to Spouse/Significant Other/Family Member

This authorization grants permission to the person named below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis and treatment plans; and have access to my financial health information.

Patient Name: _____

Date of Birth: _____ MRN # (staff use) _____

Authorized Individual: _____

Relationship to patient: _____Telephone: _____

Authorized Individual: _____

Relationship to patient: _____Telephone: _____

Authorized Individual: _____

Relationship to patient: _____Telephone: _____

□ I give my permission for CVAM to leave messages on my voicemail and/or answering machine.

□ I do not give my permission for CVAM to leave messages on my voicemail and/or answering machine.

I hereby authorize CardioVascular Associates of Mesa, PC to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to the party named above the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying CardioVascular Associates of Mesa, PC in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by CardioVascular Associates of Mesa, PC prior to their receipt of the revocation.

I understand that my treatment cannot be conditioned on whether I sign this authorization.

Patient Signature: _____

Date: _____