Zaidi Heart Clinic
Dr. Syed Zaidi
702-936-5254
800-249-1023
support@zaidiheartclinic.com
www.zaidiheartclinic.com
7170 Smoke Ranch RD STE 110
Las Vegas, NV 89128

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Compliant with HIPAA and Nevada Law – NRS 629.061)

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____

Phone Number: _____

Authorization

I, _____ (patient name), authorize **Zaidi Heart Clinic / Dr. Zaidi** to disclose my protected health information as specified below.

Recipient of Records (check one):

☐ Patient (Self)

☐ Other Individual/Entity: _____

Delivery Method (select one):

☐ Secure Email: _____

☐ Fax Number: _____

(*Mail delivery is not available.*)

Information to Be Released (check all that apply):
☐ All Medical Records
☐ Office Visit Notes
☐ Cardiology Reports (EKG, Echocardiogram, Stress Test, etc.)
☐ Medication List
☐ Test Results
☐ Other (specify): _____

(*Only the information selected above will be released.*)

Expiration of Authorization
☐ On ____ / ____ / _____
☐ Upon completion of this request

Electronic Transmission Risk Acknowledgment

I understand that if I choose to receive my medical records via email or fax, there are potential risks, including but not limited to unauthorized access, interception, or misdelivery. I acknowledge that:

- Email and fax transmissions may not be secure methods of communication.
- Once information is sent, Zaidi Heart Clinic cannot guarantee its confidentiality.
- I accept these risks and still request delivery by the method selected above.

Patient Rights & Acknowledgment

- I understand that this authorization is voluntary and I may refuse to sign it.
- I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken.
- I understand that information disclosed may be subject to re-disclosure and may no longer be protected under federal or state law.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.

Signature

Patient/Legal Representative Name: _____

Signature: _____

Date: _____

Relationship to Patient: _____

For Office Use Only

Staff Name: _____

Staff Signature: _____

Date Processed: _____

Records Release Date: _____
