Arizona Heart and Arrhythmia Clinic

AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION

Patient name: **Date of Birth**

I give Arizona Heart and Arrhythmia Clinic, and staff authority to release medical information regarding my care, to the individuals mentioned below,if unable to contact me. This authority will be perpetual, unless revoked by me.

NAME	RELATIONSHIP
____________________________	______________________________
____________________________	______________________________
____________________________	______________________________

Emergency Contact Name ____

Emergency Contact Phone number ____

Also, I give permission to leave messages regarding my test results, appointments etc., at the following numbers____

Patient signature____