ZYMEK CARDIOLOGY, PLLC

RELEASE OF INFORMATION REQUEST

Name:_____ **DOB:** _____

Address:_____

Phone:_____

I hereby authorize Zymek Cardiology, PLLC
Phone: 480-493-5152
Fax: 480-935-3783
4915 E. Baseline Road, Suite 123
Gilbert, AZ 85234

To: **RECEIVE/RELEASE** medical records **TO/FROM:**

Physician/Entity Name:_____

Address:_____ City:_____ State:____ Zip: _____

Phone:_____ Fax: _____

All records_____ Past two years_____ Specific:_____

By signing below, I authorize release of medical records including but not limited to HIV related information, communicable disease, alcohol, drug abuse, mental health, and genetic testing information also. This consent will expire in 90 days from date signed. I can revoke this authorization at any time by notify Zymek Cardiology in writing. I understand that a photocopy or facsimile of this authorization is acceptable in lieu of original.

This information has been disclosed to the recipient above from confidential records which are protected by state law that prohibits further re-disclosure of the information without specific written consent from the patient listed above. (A.R.S section 36-664 (G))

Signature:_____ **Date:** _____