Faisal Bahadur, MD
Gautam Kedia, MD
Bashar Markabawi, MD, FACC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________________________ Phone Number: ____________________
Address: ____________________________ Date of Birth: ______________________
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I hereby authorize the Lifetime Heart & Vascular / the outside practice, to receive and/or release medical records on my behalf.

☐ All health records in your practice, related to myself

☐ Specific health information:

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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer at (480) 699-5536.

The Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Or as otherwise permitted by law.

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Signature of Patient (or Personal Representative) Relationship to Patient Date

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Witness Relationship to Patient Date

(REV 9/2017)