

Valley Heart Rhythm Specialists



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Chandler, Arizona 85224

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Authorization for Disclosure of Protected Health Information

I, _____ hereby authorize:

Valley Heart Rhythm Specialists, PLLC

595 N Dobson Road, Suite A5

Chandler, Arizona 85224

to receive and may disclose my health information including complete medical records, lab reports, studies reports, operative reports, etc... in order to assist with my care.

I understand that this authorization will expire if I am no longer a patient under Valley Heart Rhythm Specialists

I understand that I may revoke this authorization at any time by written notification

I understand that I can refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or my eligibility for benefits

Patient Name: _____

Date of Birth: _____ SSN: _____

Patient/Guardian Signature: _____ Date: _____