THE INSTITUTE FOR
VEIN HEALTH

Authorization for Release of Patient Confidential Health Information

Patient name: _____

Address: _____

Phone:_____ Date of Birth:_____

I hereby authorize the protected health information regarding the above-named person to be exchanged to:

Person/Institution/Other: _____

Address:_____

Phone number: _____

The following types of information to be disclosed are as follows:

☐ History and physical examination

☐ Consultation reports

☐ Progress notes

☐ Operative reports

☐ Abstract (documents summarizing history)

☐ Diagnostic reports (labs, x-rays, etc)

☐ Other

Restrictions_____

If no restrictions are specified the health information released to the named recipient may include testing, diagnosis, evaluation and/or treatment for alcohol and/or drug abuse, HIV, mental, physical and/or emotional illness.

This Authorization is subject to revocation by the patient at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. Unless revoked, this Authorization will remain valid for 1 year after signing. Patient has the right to inspect a copy of the health information to be released and without the signature that information will not be released.

Printed name of patient, legal guardian, or authorized agent: _____

Signature of patient or legal guardian, or authorized agent: _____

Relationship to patient: _____ Date: _____

Staff signature: _____ Date: _____

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