AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Patient Name:____DOB:____________________________

Address:____

Street | City | State | Zip

Home Phone:______________________Cell:____________________Work:_______________________

My Authorization:

You may use or disclose the following health care information (Check All That Apply)

(Circle Include or Exclude for each of the following)

Include or Exclude: My health information related to drug abuse

Include or Exclude: My health information related to alcohol abuse

Include or Exclude: My health information related to HIV/AIDS

Include or Exclude: My health information related to psychological or psychiatric conditions, Including psychotherapy notes.

Specific Description:

___ Physician Notes

___ Surgery Notes

___ Hospitalization Notes

___ Lab Reports

___ Other:____

Release Information To:

Name or Organization:____

Address____

Street | City | State | Zip

Reason (s) for this authorization:

___ at my request

___ other (specify)____

This Authorization Ends:

Date:___________________

Medical Records Fee:

Records transferred to another physician that pertain to vascular condition are done at no charge. There will be a fee for any other transfer. All medical records must be paid for in advance. Transfers may be done via mail or fax.

My Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

To take part in a research study or to receive health care when the purpose is to create health Information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. To revoke this authorization, you may write a letter to the above address.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws no longer protect it.

____ ______________________ ____________

Patient or legally authorized individual signature | Date | Time

____ ______________________________________

Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, etc)