AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information

Name: _____ DOB:_____ SSN: _____

Mailing Address: _____ _____ _____ _____
street *city* *state* *zip code*

I authorize Total Vein Care to release requested Protected Health Information (PHI) to:

Agency Name: _____

Mailing Address: _____ _____ _____ _____
street *city* *state* *zip code*

Consent

The purpose of this authorization is: _____.

I authorize the release of all of the following protected health information:
Medical History, Examination, Reports, Surgical Reports, Treatment or Tests, Prescriptions, Hospital Records Including Reports, Laboratory Reports, Discharge Summaries, Complete Health Record, Diagnosis and Treatment Codes, Consultation Reports, Progress Notes, Complete Billing Record, and/or Itemized Bill.

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release any of the following records that are applicable:
Alcoholism, Drug Abuse, Mental Health, Vocational Rehabilitation, HIV (AIDS), Sexually Transmitted Diseases, Genetics, Psychotherapy Notes, Hepatitis B or C Testing, and/or Other Sensitive Information.

I do not authorize the release of the following types of my health information: (if none, leave blank)

_____

Please provide medical records for the time period of _____ through_____.

Right to Revoke:
You may revoke this authorization at any time giving written notice of revocation to Total Vein Care at 8888 Summa Ave 3rd Fl., Baton Rouge, LA 70809. Revocation of this authorization will not affect any action we took in reliance on this authorization and will not affect any action we took in reliance on this authorization before we received your written notice of revocation.

This authorization to release medical information shall expire on: _____.
date

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read and understand all aspects of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

_____ _____
signature *date*