MIDWEST VASCULAR
& VARICOSE VEIN CENTER

Patient Name: _____
Patient DOB: _____ SSN: _____
Driver's License #: _____
Address: _____
_____
Phone: _____ Payment: _____

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

I, _____, authorize the custodian of records of Midwest Vascular and Varicose Vein Center, LLC to disclose/release the following information* (check all applicable):

☐ All records ☐ Laboratory/pathology records
☐ X-ray/radiology records ☐ Billing records
☐ Abstract/Summary ☐ Pharmacy/prescription records
☐ Other (describe specifically) _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

The information may be used/disclosed for each of the following purposes:

☐ At my request (only the patient can check this box) ☐ For my health care
☐ For payment/insurance ☐ For employment purposes
☐ Other: _____

If patient requests medical records and would like to have someone other than themselves pick up the documents, patient must print name of person authorized to do so: _____

These records are for services provided on the following date(s):_____

Please send the records listed above to (use additional sheets if necessary):

Name: _____, Relationship to Patient: _____
Address: _____
Phone: _____, Fax: _____

This authorization shall expire no later than one year from the date of signature or upon receipt of written request for termination is submitted to this office (whichever is sooner). You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by submitting a written request.

I understand that after the custodian of records discloses my health information, federal privacy laws may no longer protect it. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that are no claims or orders pending or in effect, that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's relation to patient