LONGSTREETCLINIC
Vascular & Vein

Authorization for the Release of Medical Information

Patient's Name: _________________________________ Date of Birth: ___________

Date: _________________ Physician you are seeing today: __________________

I give my consent and authorize Vascular and Vein Specialists at Longstreet Clinic to release any medical records including but not limited to records, reports, notes, chart notes, letters, photographs, test reports or results (including physical test results, pathology test results, laboratory test results, x-rays, MRI & CAT scans, EKG's, etc.), financial information (including insurance information and/or billing statements), and referral letters. I also consent and authorize the discussion of medical records and information pertaining to me or my treatment. I understand I am authorizing the release of this information to the following individuals:

____________________	____________________	____________________
Name	Relationship to Patient	Phone Number
____________________	____________________	____________________
Name	Relationship to Patient	Phone Number
____________________	____________________	____________________
Name	Relationship to Patient	Phone Number

This release of information is intended to include records maintained in my maiden or other names as follows: ____

I understand Vascular and Vein Specialists at Longstreet Clinic may not make my completing and signing this authorization a condition of my treatment.

I understand that I am authorizing the use or disclosure of my protected health information as described above. I understand that information released may no longer be protected under the HIPAA rules and regulations. I understand that I may be charged for any copies provided. I may revoke this authorization at any time in writing.

I have read, understand and agree to the above stated policy.

____ ___________________________

Patient Signature Date