Authorization for Release of Information

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS Revised 08/04/2015 HD
In accordance with Federal Government Privacy Rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for Vascular Institute of the Pines to discuss your condition or appointments with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

Please Initial Applicable Blanks

_____ I authorize Vascular Institute of the Pines to take photos for my chart and/or publish them while maintaining my patient confidentiality.

_____ I authorize Vascular Institute of the Pines to send or request any correspondence regarding your condition and care to the referring or family/primary care physician provided in the record.

_____ I authorize Vascular Institute of the Pines to release any or all information concerning my medical care to anyone I list below.

_____ I do not authorize my photos to be published.

_____ I do not authorize anyone to obtain medical information about me or my appointments.

Name: _____ Relationship to the patient: _____

Name: _____ Relationship to the patient: _____

Patients Name: _____ Patients Date of Birth: _____

Patient Signature: _____ Todays Date: _____

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