PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:______________________________ Date of Birth:__________________________

Phone: H) _________________________________ Phone: W) ____________________________

Address: __________________________________ City/State/Zip: _________________________

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: Total Vein Care Facility Phone: 479-434-5350

Facility Address: 12112 Highway 71 S Facility Fax: 479-434-5355

City, ST, Zip: Fort Smith AR 72916

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

The purpose of disclosure is:

- Change of Insurance or Physician
- Continuation of Care
- Referral
- Other_________________________________
- Dates of Treatment from_______to_______

Dates and Type of information to disclose:

- Progress Notes
- Operative Reports
- Test Reports
- Specific Information Requested: ____________________________________

This information may be disclosed and used by the following individual or organization:

Release To: ____

Address: ____

City, State, Zip: ____ Fax:_______________ Phone:_______________

- Please mail records.
- Electronic copy on CD ($5.00 Fee)
- Please Email records.
- Please fax records.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: __________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

X____ **Date:**___________________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

____ ___________________________

Printed name of Authorized Representative Relationship / Capacity to patient