Commonwealth Vascular Institute
C. **Matthew McBee, M.D., F.A.C.S., RVPI**
150 Burnett's Way, Ste. 200
Suffolk, VA 23434
(757) 539-7824

Patient Name: _____

DOB: _____ Last 4 of SSN: _____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

*****You have the right to refuse to sign this authorization*****

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand if my record contains information related to substance abuse, HIV and/or mental health, the information will be release with my medical record.

Persons/Organizations receiving information:

_____ _____

_____ _____

Ph:_____ F: _____ Ph:_____ F: _____

Information to be disclosed, covering the period of health care:
☐From _____ to _____ **----OR----** ☐Complete health record

----OR---- Please select from the following (check as many as apply and please provide dates, if available):

☐ Office notes _____ ☐ Laboratory Tests _____

☐ Pathology reports _____ ☐ X-ray reports _____

☐ Procedure reports _____ ☐ other (please specify) _____

This information is to be disclosed for the purpose of: _____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire 1 year from the date signed below. **Initials:** _____
b. I understand that I may revoke this authorization at any time by notifying CVI in writing. If I do, it won't have any effects on any actions CVI took before it received the revocation. **Initials:** _____
c. I understand that CVI cannot make me sign this authorization as a condition to receive treatment from CVI except:
    a. When CVI provides me with research-related treatment; or
    b. When CVI provides me with health care solely for the purpose of creating protected health information for disclosure to someone else. **Initials:** _____

Commonwealth Vascular Institute, its employees, offices, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name Relationship/Representative to patient

Please describe the representative's authority to act on behalf of the patient (i.e. parent, legal guarding, power of attorney, care-taker, etc.) _____