AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 or release the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize the release and disclosure of the following information from the medical records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Patient Number: _____

Covering the period(s) of health care:
From _____ to _____

Information to be disclosed:

☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images
OR
Select from the following (check as many as apply):

☐ Discharge Summary
☐ History and Physical Examination
☐ Consultation Reports
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray reports

☐ Other (please specify) _____
_____

This information is to be disclosed to the following individual or entity:

☐ Commonwealth Vascular Institute (Downtown Suffolk)
150 Burnett's Way, Suite 200
Suffolk, VA 23434 P#: 757-539-7824 F#: 757-538-9474

☐ Commonwealth Vascular Institute (Harbour Breeze)
1520 Breezeport Way, Suite 100
Suffolk, VA 23435 P#: 757-539-7824 F#: 757-538-9474

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION