Medical Records Release Form

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name:________________________________**DOB:**_____ /_____ /______**Phone:**_____________

Release Details	
I authorize The Vascular Care Group, LLC to disclose the following health information (check one):	
☐ All of my health information	☐ My health information relating to the following treatment or condition: ____ ____
☐ My health information covering the period from ___________ (date) to __________ (date)	☐ Other: ____ ____
This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.	
☐ I consent to have the above information released.	☐ I do not consent to have the above information released.
This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.	
☐ I consent to have the above information released.	☐ I do not consent to have the above. information released.

Recipient	
The Vascular Care Group, LLC may disclose this health information to the following recipient:	
____________________________ Recipient Name	____________________________ Phone
____________________________ Street Address	____________________________ Fax
____________________________ City, State, Zip Code	

Rights
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Authorization Expiration

Unless otherwise noted below, this authorization shall remain valid for a period of **90 days** after receipt of signature.

Preferred Date of Expiration ______________________________________

Signature

Patient Signature: ____ **Date**: ______________________

If the patient is a minor or unable to sign, please complete the following:

☐ Patient is a minor (indicate age): ______________ years of age

☐ Patient is unable to sign because: ____

Authorized Representative Name:____

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other: _____________________________

Authorized Representative Signature:________________________________ **Date**: _________________