PACIFIC VASCULAR SPECIALISTS

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ hereby authorize the release of medical records as indicated below:

Regarding the following Individual

Name of Patient: _____

SS#: _____ DOB: _____

From Facility: _____	**To Facility:** _____
Provider:_____	Provider: _____
Address: _____	Address: _____
_____	_____
PH: _____	PH: _____
FX: _____	FX: _____

Specifically, I authorize the use or disclosure of the following information:

☐ Complete Medical Record ☐ Clinic Chart notes/ Progress notes

☐ Hospital Records ☐ Lab Reports

Other: _____

Date range of records: From: _____ TO: _____

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ Information regarding the patient's diagnosis and treatment of HIV/AIDS.

_____ Psychotherapy notes

_____ Treatment for alcohol or drug abuse.

This protected health information is being used or disclosed for the following purposes?

_____

This authorization shall be effective FROM: _____ **TO:** _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the Clinic has relied on the use of disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. The Clinic will not condition my treatment, payment, enrollment in a health plan or eligibility for benefit (if applicable) on whether I provide authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under applicable Federal and State Law. I understand that I also have the right to refuse to sign this authorization. Unless revoked earlier, this authorization will expire in 180-days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. To the extent permitted by law, the Clinic, its employees, officers, 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/ Personal Representative/ Description of Personal Representative's Authority **Date**