Vascular Surgical Associates, P.C.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Vascular Surgical Associates, P.C. to disclose the following information from the health records of:

Name:_____
Last First MI Previous Name

Birthdate: _____ **Account number#:**_____

Telephone: _____

Address: _____
Street City State Zip

This information is to be disclosed only to (list any relatives or friends who are allowed access to your information):

1._____ **3.**_____

2._____ **4.**_____

Covering (Date(s) of service):

From (date)_____**to (date)**_____ **or**

_____ **All dates of service (please initial if all dates desired)**

For the purpose of _____

The following information may be released:

_____

I understand that this will include information relating to (check and initial only if applicable):

- ☐ **Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.**
- ☐ **Behavioral health service/psychiatric care.**
- ☐ **Treatment for alcohol and/or drug abuse.**

Affirmation of Release: I give Vascular Surgical Associates, P.C. permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

Signature of the Patient/Guardian/Legal Representative **Date Signed**

_____ _____