CENTER FOR Vascular Medicine

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION PROTECTED HEALTH

Section 1 Patient Information

FIRST NAME: _____LAST NAME _____ DATE OF BIRTH: _____

ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

PRIMARY PHONE: (_____)_____ SECONDARY PHONE: (_____)_____

Section 2 Retrieval/Release Information

RETRIEVE / RELEASE INFORMATION FROM / TO:

☐ I hereby authorize Center for vascular Medicine to OBTAIN my protected Health information, as indicated Section 3, FROM:

☐ To RELEASE my Protected Health Information, as indicated in Section 3 TO:

NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

Section 3 Information to be released

INFORMATION TO BE RELEASED

INFORMATION:

- ☐ History and Physical exam
- ☐ Lab Reports
- ☐ Operative / Surgical Notes- Only
- ☐ X-ray reports
- ☐ Procedure images (USB)
- ☐ Consult / Follow up Notes
- ☐ Ultrasound interpretations – Only
- ☐ EKG report
- ☐ Other(Specify) _____

I specifically authorize the release of information relating to:

- ☐ Substance abuse (Including alcohol/ drug)
- ☐ Mental health (excluding psychotherapy notes)
- ☐ HIV related information (including AIDS related testing)

X_____ _____

SIGNATURE PATIENT OR AUTHORIZED PERSON DATE

Section 4 Purpose of Release Request

PURPOSE OF RELEASE REQUEST?

- ☐ Changing Physicians (Reason)_____
- ☐ School
- ☐ Continuing care
- ☐ Personal use
- ☐ Legal / Atty
- ☐ Insurance / Disability

INFORMATION TO BE RELEASED – *(Records, Timeframe Media and Delivery Method)*:

Preferred Delivery Method *(Select One):*	☐ - **Mail *('To' address below)***	☐ - Pick-Up Records *(CVM will contact you to coordinate.)*
	☐ **Address:**	☐ - Fax #*(Clearly Print below)*

Section 6 Patient Notification Elements

PATIENT NOTIFICATION ELEMENTS

1. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected by Federal privacy regulations.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
3. **Most State laws permit up to 30-days to process record requests, however records for treatment purposes can be faxed to the patient's healthcare provider when requested. As permitted by State law, CVM may collect reasonable costs to reproduce your records (a cost estimate will be provided prior to record release).**

_____ _____ _____

PRINTED NAME OF PATIENT | SIGNATURE OF PATIENT (Or Personal Representative) | DATE

Return Signed Authorization Form to:

Center for Vascular Medicine
7300 Hanover Drive Suite 104
Greenbelt MD 20770
Phone: (301)486-4690 FAX# (301) 441-8809

CVM USE: Delivery (How/Who/When):