

Vein and Vascular Center of South Florida
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ authorize **Vein & Vascular Center** to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medication information and billing information to the following named persons*.

1. _____ 3. _____
2. _____ 4. _____

Only persons listed above will be able to receive information related to your care. This office will not be able to disclose information to any other persons.

*You may change, expand or restrict this list at any time.

PREFERRED COMMUNICATIONS

Please list the phone number and address where you would like us to contact you for:

- Results – lab, X-ray, Ultra sounds, etc.
- Reminder notices
- Changes on scheduled appointments
- Billing information

Telephone: _____

Patient's Last Name

First

Middle

Street Address

City

State

ZIP Code

X

PATIENT/GUARDIAN SIGNATURE

Social Security Number

DATE