Texas Health
Vascular Surgical Specialists

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name:_____ Phone Number:_____

Date of Birth:_____ Social Security Number: XXX -_____-_____

I authorize **Texas Health Vascular Surgical Specialists** to ❑ Release ❑ Obtain protected health information..

I request that the following protected health information be released:
(Check all which best describes the information to be released and disclosed)

❑ Clinic Notes	❑ Consultation Report	❑ Immunizations	❑ All Records
❑ Procedure Notes	❑ EKG Reports	❑ Medication/Prescription List	
❑ Lab/Pathology Reports	❑ Radiology Reports	❑ Problem List	
❑ Behavioral Health	❑ Radiology Images	❑ Other:_____	

I understand the information to be released or disclosed may include information relating to treatment or testing for sexually transmitted diseases, transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) psychological or psychiatric treatment, behavioral or mental health services, and alcohol and drug abuse. I authorize the release or disclosure of the type of information described in this section.

I request the protected health information be: ❑ Released to ❑ Obtained from

Name (Individual or Organization): _____

Address: _____

_____

Telephone Number: _____ Fax Number: _____

THE PURPOSE OR REASON THIS INFORMATION IS NEEDED: (Please check all that apply.)

❑ Legal Purposes	❑ Insurance	❑ Personal Use	❑ Medical Care	❑ Military
❑ Social Security Disability	❑ Workers Compensation	❑ VA Medical Center	❑ School	

(Social Security, Workers Comp and VA Medical Center requests require documentation of a pending claim.)

❑ Other: _____

I understand the following:

1. I have a right to revoke this authorization in writing at anytime except to the extent action has been taken in reliance upon this authorization.
2. The information released in response to this authorization may be re-disclosed to other parties and can no longer be protected by this health care provider.
3. My treatment or payment for my treatment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.
4. I may be charged a fee for copies of these medical records according to State and Federal Laws.

This authorization will expire One Hundred Eighty (180) days from the date signed below.

_____ _____ _____
Patient or Legally Authorized Representative Signature | Patient or Legally Authorized Representative Printed Name | Date

_____ _____
Relationship to Patient | Telephone Number

PATIENT IDENTIFICATION