PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security #: _____

By signing this authorization, I authorize Vascular Specialists of Central Florida, Inc. to obtain / release (please circle that which applies) certain protected health information (PHI) about me from/to:

_____

_____

_____

(Name and address of entity being asked to release information or the entity to which the information will be forwarded)

The information requested to be obtained from the entity listed above should be sent to:

Vascular Specialists of Central Florida, Inc.
80 West Michigan Street
Orlando, Florida 32806
Ph 407-648-4323 Fax 407-839-1493

This authorization permits the following individually identifiable health information about me to be obtained/released:

- ☐ My complete medical record
- ☐ Visit services provided by only the following physician(s) or other practitioner(s) _____

_____

- ☐ Office/Outpatient/Inpatient Diagnostic Testing
- ☐ Alcohol and/or drug abuse
- ☐ Operative reports for invasive/surgical services
- ☐ Medication Lists
- ☐ HIV testing/diagnosis
- ☐ Other _____
- ☐ Laboratory Results

The information will be used or disclosed for the following purpose: (check one)

- ☐ My records only
- ☐ Transferring Care to _____
- ☐ I am moving out of area.

My new address is: _____

_____

Signed: _____ Today's Date: _____

Signature of Patient

_____ _____

Signed by Personal Representative/Guardian (if applicable)

Print Personal Representative/Guardian Name Relationship to Patient

For Internal Purposes Only

Completed by: _____ Date completed: _____

☐ Fax ☐ Pick-up ☐ Mailed ☐ Other