MINNEAPOLIS VEIN CENTER
Experts in Vein Care

AUTHORIZATION FOR RELEASE OF INFORMATION

MR #______________________

Patient's Name: ______________________________________

Birthdate: ________________________________ Phone Number: ___________________________

This will authorize ____
(Name/Dept/Address)

to release information to: ____
(Name/Title of Person/Organization)

____
(Address) (City) (State) (Zip)

Phone #: ______________________ Fax #: ____________________________

Information to be released includes records from the following dates:___________________________

Information to be released:

______ Consultation Reports
______ History & Physical Examination
______ Laboratory Reports: __________________
______ Nurses Notes
______ Operative Reports
______ Physician Progress Notes
______ Radiology Reports
______ Other (specify):

Reports released may include information about mental status/drug/alcohol and HIV testing results. If there is specific information that you do not want released, please write here:

____

The information is needed for the following purpose: ______________________________________

Information to be released via: ☐ Mail ☐ Pick-up ☐ FAX

This authorization will expire upon the earliest of the following dates: 1) twelve months following date of signature on this form, 2) the date the stated purpose is fulfilled, 3) the date I write here ____________________, 4) the date that I revoke this authorization.

I understand that I may revoke this authorization at any time by writing a statement to the authorized releaser as noted above except to the extent that Minneapolis Vein Center has relied on the authorization.

I understand that I may be charged a fee for the costs of copying records or for preparing a summary or explanation of records, subject to state and federal law.

A photocopy or facsimile of this authorization shall be treated as valid as the original.

I understand that once this information is disclosed, it may no longer be protected under the Federal Privacy Regulations and that the recipient might redisclose the information.

____ Date: _____________________________
Signature of Patient or Patient's Representative
Must be filled in

(If Patient's Representative, under what legal authority are you signing?)
☐ Parent ☐ Guardian ☐ Health Care Agent
☐ Other (specify): ______________________________