

VEIN CENTER OF CHARLOTTE - FAMILY/FRIENDS INFORMATION RELEASE FORM

Name of Patient: _____ Date of Birth: _____

I authorize the Vein Center of Charlotte to release protected health information to the entities named below:

Give information to spouse: Yes ___ No ___ N/A _____

Name of spouse: _____

Give information to a family member or friend, please list: _____

Contact me at work: Yes ___ No ___ N/A _____

Description of Information to be released to the named person above:

Financial/Billing: Yes ___ No ___

Medical information: Yes ___ No ___

Please list any restrictions regarding information to be released: _____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclose as described in this document by sending a written notification to Vein Center of Charlotte. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective immediately upon receipt of notification by Vein Center of Charlotte.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

Signature of Patient or Personal Representative Date: _____

Description of Personal Representative's Authority (attach necessary documentation)