

Authorization for Release of Medical Records

General & Vascular Surgeons, PC

Phone: 623.434.7373

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I. Patient Information

Name: <<Pat_FirstName>> <<Pat_LastName>> Date of Birth: <<Pat_BirthDate>>

II. Release Information

Information to be released **from** (Name of Facility or Provider):

Address of Facility/Provider: _____

Phone #: _____ Fax #: _____

Information to be released **to**:

Address of Facility/Provider: _____

Phone #: _____ Fax #: _____

◆ Information to be Released (Please mark one from list below):

- ALL Medical Records
- Medical Records for the following dates: _____
- Medical records relating to the following treatment/ condition:

- Other (specific testing such as ultrasound, x-rays, etc): _____

◆ The following information may be released regarding testing, diagnosis, and treatment for: (check all that apply)

HIV/ AIDS virus Sexually Transmitted Diseases Drug and/or Alcohol Use
 Psychiatric Disorders/ Mental Health

◆ Reason for Release:

Personal Doctor Attorney Insurance
 Other: _____

III. Patient Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment.) HOWEVER, some facilities will not release information without a signed authorization as part of their policies. To revoke or amend this authorization, I must send a written request to General & Vascular Surgeons, P.C. This information may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

This authorization expires on: _____ (if left blank, the authorization will expire 1 year from the date of this authorization)

Patient or legally authorized representative signature*

Date

Printed Name of legally authorized representative

Relationship

*If signing as Power of Attorney (POA), we must have a copy of the POA documents on file before we can release the documents.