John V. White, MD **Vascular Surgery**
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AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

I hereby authorize that the protected health information regarding the above named person be forwarded:

FROM: Person/Institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

TO: Person/Institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Purpose or need for information: _____

_____

Disclosure will include (check all that apply):

☐ Face Sheet ☐ History and Physical ☐ Operative Report

☐ Progress/Physician Notes ☐ Diagnostic/Radiology Reports ☐ Laboratory Data

☐ EKG ☐ Pathology Reports ☐ Other _____

For the Period (dates) from _____ to _____

I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the contact person at this practice site except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in one year after signing. I have the right to inspect the copy of the health information to be released and if I do not sign this authorization, the physician practice named above will not release my health information. The above named physician practice will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient

_____
Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that the health information disclosed under this authorization may be re-disclosed by the recipient to others. Federal laws, rules, and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug or alcohol abuse.