HILL | VASCULAR & VEIN CENTER

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name_____Date of Birth:_____

By signing this form, I authorize _____
to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to:

HILL VASCULAR & VEIN CENTER
3803 S. Bascom Avenue, Suite 204
Campbell, CA 95008
Phone: 408-770-HILL (4455) | Fax: 408-770-4770 | frontdesk@hillvascular.com

Please identify the information to be released:

_____ Release entire record -OR-_____Please Specify: _____

The identified information will be used for the following purpose:

_____ Continuing care and treatment -OR-_____Other (please describe):_____

- I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice.

The identified information may be used by or released to *Hill Vascular & Vein Center*.

Patient Signature:_____Date:_____

Signature of person completing this form if not patient: _____

Relationship:_____Date: _____

Witness (Practice Employee):_____Date: : _____