AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name

Birth Date

I hereby authorize:

to use and/or disclose my protected health information to:

- ATLANTIC VEIN INSTITUTE, 7 GRAF ROAD, NEWBURYPORT, MA 01950
- Other Provider_____

for the purpose(s) of:

- Transfer of care (reason)_____
- Communication with other providers, physicians, insurance review
- Other (reason)_____

Dates of care included: _____ to_____

- Complete copy of medical records
- Specific records only (specify)_____

The information authorized for disclosure may relate to: (check all that apply)

- Sensitive information (specify)_____
  __ Mental Illness __HIV/AIDS tests/treatments __Hepatitis A,B,C __Drug/Alcohol treatment

- I understand that I may inspect of copy the protected health information described by this authorization.
- I understand that I may revoke this authorization at any time by notifying Atlantic Vein in writing; however, such revocation does not affect any actions taken on this authorization before receipt of said revocation.
- I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that Atlantic Vein shall not condition my treatment on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.
- I understand that my physician shall have the opportunity to obtain direct or indirect remuneration in the nature of administration and copying fees from a third party as a result of this authorization.

Signature of individual or representative (state relationship) **Date**

This authorization will expire on: (date/event) _____

*If no date is stated, expiration is 6 months from the date it was signed