AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize (provider) _____ Provider Phone # _____

Address: _____ Provider Fax # _____

City, State , Zip: _____

To release health/medical information of:

Patient's Full Name: _____ Date of Birth: _____

This information is to be released to:

Requesting Provider: _____

Western Vascular Institute
7165 E University Drive #183
Mesa, AZ 85207
Telephone: 480-668-5000 Fax: 480-668-5065

For the purpose of:
- ☐ Permanent Transfer to new provider
- ☐ Consultation with:
- ☐ Other

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually-transmitted diseases, etc., unless herein excepted:

_____

This release includes specifically:

Office Notes:	Laboratory Reports:
Complete Record:	Radiology Reports:
History & Physical:	EKG:
	Other:

Covering records from:

1) the period from _____ to _____

2) date of service _____

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS FROM THE DATE SIGNED, OR UNTIL THE FOLLOWING EVENT OR CONDITION

_____

SIGNATURE (person authorizing release): _____

Date of Signature: _____ Relation to Patient: _____