AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize	Western Vascular Institute	Phone #	480-668-5000
Address:	7165 E University Drive #183	Fax #	480-668-5065
City, State , Zip:	Mesa, AZ 85207		

To release health/medical information of:

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

This information is to be released to:

I authorize	_____	Phone #	_____
Address:	_____	Fax #	_____
City, State , Zip:	_____		

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: _____ Relationship to Patient: _____