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Patient Signed Authorization to use and Disclose PHI to Specific Individuals

I have read and understand the information regarding the use and disclosure of Patient Health Information. I have received a copy of this form and I am the patient or individual authorized to act on behalf of the patient.

Chart Number (to be filled in by practice): _____

Patient Name: _____

Address: _____

Telephone: Home:(_____)_____-_____ Cell: (_____)_____-_____

Patient Authorization to Release Information

I, (PRINTED NAME) _____, herby authorize Vascular Solutions of North Carolina to release the following information to the individuals listed below:

- ☐ Consult Notes
- ☐ Office Visits
- ☐ Procedure Notes
- ☐ Imaging Reports
- ☐ Medical Records
- ☐ Other: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____

Printed Name: _____

Date: _____/_____/_____

First Initial: _____ Last Name: _____