AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize American Vascular Access to disclose my individually identifiable protected health information (PHI) as described here to the person/organization named below.

Section A. Complete all sections

Patient Name:	Birth Date:	Social Security No.:

Patient Address:

Name and Address of person (s) or organization (s) to whom this information will be sent:

This authorization will expire on the following: (Fill in the date or the event, but not both.). If I do not indicate a date, this will expire one (1) year from the date of my signature below.

Date:_______________________________ Event:____

Purpose of disclosure:

Description of information to be released:

Medical record from (insert date) _________________________ to (insert date) _________________________

Check the appropriate boxes:

☐ Entire Record	☐ Medication Reports	☐ Other: _____________________
☐ History and Physical	☐ Radiology Reports	
☐ Operative Reports	☐ Nursing Notes	
☐ Consultation Reports	☐ Physician Progress Notes	
☐ Laboratory Reports	☐ Physician Orders	

The following information will not be released unless you specifically authorize its disclosure by *initialing* the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to mental health treatment

_____ I specifically authorize the release of information pertaining to alcohol and/or drug abuse

_____ I specifically authorize the release of information pertaining to confidential HIV (AIDS) related information

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the release of the protected health information as stated.

Signature of Patient or Representative Authorized by Law*:	Date:
Print Name of Patient or Representative Authorized by Law:	Relationship to Patient:

Section C: Office use only. Complete all sections.

Received by: ____ Date form received: ________________________

Delivery method: ☐ FAXED ☐ MAILED ☐ IN PERSON

Attending physician's signature authorizing release: ____

REPRESENTATIVE AUTHORIZED BY LAW MUST SUBMIT COPIES OF LEGAL DOCUMENTS SUPPORTING AUTHORITY TO ACT ON THE PATIENT'S BEHALF.