THE VASCULAR GROUP

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SECRETARIES: FAX 518-262-6720 MEDICAL RECORDS FAX: 518-262-9413

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:		Date of Birth:	/ /
Social Security #:	- -		
I request and authorize (Name of Proxy /Firm): to release healthcare information of the patient named above to:			
Name:			
Address:			
City:	State:	Zip Code:	

This request and authorization applies to:

☐ **Today's Office note and/or Lab Testing**
_____/_____/_____
Please note that this will include Ultrasounds/PVRS/Mapping/CT Scans/ and Blood Work **performed at your dated appointment**

OR

☐ **Most recent records (Vascular records ONLY** - including Ultrasounds, Office Visits, and Surgeries)
from : ____/____/_____ to ____/____/_____
(Or) ____/____/_____ to Today's Date

☐ **Complete Medical Chart:**
With the exception of:
- ☐ Mental Health Records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/Drug Abuse Treatment
- ☐ Other:

Please specify_____

****Please note that if you are requesting your COMPLETE MEDICAL CHART-this can EXCEED 100 pages and will be processed in several business days. ****

- I understand that I have the right to revoke this authorization at any time by sending my written revocation to:

THE VASCULAR GROUP, PLLC, ATT: Medical Records, 391 Myrtle Avenue, Suite 5, Albany, NY 12208

- I understand that the revocation will not apply to any information released prior to the receipt of my written notice.
- I understand that completion of this form is not a condition of treatment.
- I understand that any information used or disclosed under this Authorization may no longer be protected by privacy laws and may be subject to re-disclosure by the person or organization receiving or using it.
- I understand that this Authorization will expire ninety (90) days from the date I sign **UNLESS** A longer period is indication here____/_____/_____ OR _____(E.G. Termination of Care)

Signature of Patient or Personal Representative: & Relation		Date	/ /