Montgomery Vascular Surgery, P.C.

Authorization for Release of Health Information

Patient Name: _____ Date of Birth: _____

Social Security: _____

Patient Address: _____

I authorize Montgomery Vascular Surgery to release health information to:

_____

Name of person/facility to receive health information Title (if known)

_____

Street address, City, State, Zip code

Information to be released

- ○ Complete Medical Records (no Billing)
- ○ Consultation notes
- ○ History & Physical
- ○ Office notes
- ○ Billing statements

Purpose of this release (check all that apply)

- ○ Continuity of care or discharge of planning
- ○ At the request of the patient/patient representative
- ○ Billing & payment of bill
- ○ Other (state reason)

_____

Notice

Montgomery Vascular Surgery and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the release of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state and federal confidentiality laws.

My Rights

I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) obtaining information in connection with eligibility or enrollment in a health plan, 2) determining an entity's obligation to pay a claim, or 3) creating health information to provide to a third party. Under no circumstances however, am I required to authorize release of mental health records.

Expiration of authorization

Unless otherwise revoked, this authorization expires upon the completion of this request.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____

Printed Name

_____

Witness