California Vein Specialists

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Explanation: This authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected information ("PHI") about the patient identified below. Please provide all requested information.

Patient Name:_____ DOB:_____

Home Phone:_____ Cell Phone:_____

1. Persons authorized to disclose PHI: I authorize the following person(s) or class of persons to disclose my health information as described in section 2 below:

J. Michael Leary, MD, and his affiliates, agents and staff.

2. Description of information: This authorization permits for use and/or disclosure of the following information:

❑ All information contained in my medical record. Except (optional)_____
or

❑ Only the records for the following dates of types of health information:

Date(s) of treatment:_____ Type of Treatment:_____

3. Authorized uses and recipients: I authorize the following person(s) or class of persons to receive and/or use the health information described in Section 2 above (the person receiving the information must be 18 years of age or older).

- ❑ Myself. I would like a copy of my medical record.
- ❑ Send to Dr. _____

  Address:_____

  Phone:_____ Fax:_____

4. Right of revocation: I understand that I have the right to revoke this Authorization in writing at any time, except to the extent a California Vein Specialists associate has already taken action based on this authorization.

5. Automatic one-year duration: This authorization will automatically expire after one (1) year from the date of execution unless a different end date is specified. End date:_____

SPECIFIC UNDERSTANDING:
I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the person listed in Section 1 will not condition my treatment or payments for signing this authorization. I understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule.

Patient Signature:_____ Date:_____