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 health information ("PHI") about the patient identified below. Please provide all requested information.

Patient Name:_____ DOB:_____

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 Section 2 in below:

Name of Dr. to release medical information:_____

Address:_____

Phone:_____ Fax:_____

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 hereby authorize the following persons or class of persons to receive and/or use the health information described in Section 2 above.

California Vein Specialists, John Michael Leary, MD
400 Westminster Ave., Newport Beach, CA 92263
Tel: 949-515-9377 Fax: 949-515-9378

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:

By signing this authorization form, I understand and agree to the use and disclosure of my protected health information as specified above.

Patient Signature: _____ Date: _____