Authorization of Release of Information to Family and/or Friends

Name of Patient: ____ Date of Birth: _______________

I authorize Vein Centers for Excellence of Greenville to release protected health information to the entities named below:

Give information to spouse/partner: ⬭ Yes ⬭ No ⬭ N/A

Name of spouse/partner: ___________________________________

Give information to a family member or friend, please list: __________________________________

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Primary Contact Number: ________________________

Contact me at work: ⬭ Yes ⬭ No ⬭ N/A

Leave message at work: ⬭ Yes ⬭ No ⬭ N/A

Leave message at home: ⬭ Yes ⬭ No ⬭ N/A

Description of Information to be released to family or friend:

Financial/Billing: ⬭ Yes ⬭ No

Medical Information: ⬭ Yes ⬭ No

Please list any restrictions regarding information to be released: ______________________________________

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Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Vein Centers for Excellence of Greenville. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective immediately upon receipt of notification by Vein Centers for Excellence of Greenville.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

____ Date: ____________________

Signature of Patient or Personal Representative

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Description of Personal Representative's Authority (attach necessary documentation)