Alabama Vein Center

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I ________________________________authorize Alabama Vein Center to use and/or disclose my protected health information/medical records to the following: (Please list below the name of the physician or company along with the address, phone number, and fax number to where the medical records are to be sent.)

Physician Name ____

Physician Address ____

Phone number ____

Fax number ____

If requested by the patient, please list "at the request of the individual". Please list your personal home address below to be mailed.
MEDICAL RECORDS CAN NOT BE FAXED TO A HOME NUMBER OR AN UNSECURED FAX

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Signed by:

_______________________________ _______________________________
Signature of Patient or Legal Guardian Relationship to Patient

_______________________________ _______________________________
Patient's Name Date

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Patient's Date of Birth

_______________________________ _______________________________
Print Patient Name or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION