Alabama Vein Center

PATIENT AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS AND OTHER DOCUMENTS CONTAINING PERSONAL HEALTH INFORMATION (PHI)

By signing this authorization, I authorize _____ to disclose my medical records or protected health information (PHI) about me to:

ALABAMA VEIN CENTER
700 MONTGOMERY HWY,STE 210
VESTAVIA HILLS, AL 35216

The patient indicates that the information will be disclosed at the request of the patient for the following purpose(s): _____

I have been advised that when my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and my no longer be protected as confidential.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient or Legal Guardian Relationship to Patient