Authorization to Release Medical Records

Patient Name: ___________________________ Date(s) of Services: ________________________

Date of Birth: ___________________________ Social Security Number: ___________________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above-named patient maintained by Vascular & Interventional Institute of Louisville. I hereby authorize the release of this information and records to:

Name:____

Fax:____

Address: ____

Contact Person (if applicable):____

PATIENT INFORMATION IS NEEDED FOR:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Military
- ☐ Other: ____
- ☐ Personal Use
- ☐ School
- ☐ Social Security/Disability

INFORMATION TO BE RELEASED OR ACCESSED:

- ☐ History & Physical
- ☐ Operative Reports
- ☐ Lab/Path Reports
- ☐ Consultation Report
- ☐ Other:
  ____
  ____
- ☐ Discharge/Death Summary
- ☐ X-Ray Reports/Images
- ☐ Emergency Room Record
- ☐ Face Sheet

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Patient/Legal Guardian Signature: ______________________________ Date: ______________

Print Name (and Relationship if applicable): ____