Varicosity Vein Center

Records Release Authorization

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

The above patient authorizes Varicosity, LLC to disclose medical records. Only medical records originating from Varicosity, LLC will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

Release to: _____

Address: _____

City: _____ State: _____ Zip: _____

Fax: _____ Phone: _____

☐ **Please mail records.** ☐ **Please fax records.**

I may revoke this authorization at any time. If I revoke this authorization, it must be in writing and presented to the Office Manager of Varicosity, LLC. A revocation will not apply to any information already released in response to this authorization or information released when my insurer has the lawful right to contest a claim under my policy. **I understand all of the above and unless otherwise revoked, this authorization will expire on the following date or condition:** _____

Authorizing this disclosure of medical records is voluntary. I do not have to sign this document to ensure I receive treatment. I can obtain a copy of the disclosed information and if I have any questions, I can contact the Office Manager of Varicosity, LLC. **I have read the above Records Release Authorization and do acknowledge that I fully understand the terms and conditions of this authorization.**

Signature of Patient or Authorized Representative: _____ **Date:** _____

Printed Name of Authorized Representative: _____ Relationship : _____

If you have any questions regarding this authorization form, please contact us.

Varicosity Vein Center

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