Vascular Institute of Michigan

1325 S. Linden Road Flint, MI 48532
Phone: (810) 535-5555
Fax: (810) 275-1556

Patient Authorization to Release Medical Information and Acknowledgement of Receipt of Privacy Notice

Patient Name (Print) _____ D.O.B _____

_____ I authorize Vascular Institute of Michigan to use or release/disclose my health information as described below.

Please identify the information to be released.

☐ Please release my entire record

OR

☐ Please release only the following information (check appropriate boxes and include other information where indicated)

- ○ Problem list
- ○ Medication and allergy list
- ○ Most recent history and physical
- ○ Lab results
- ○ X-ray
- ○ Other (please describe) _____

Please initial each item below to indicate that you understand

_____ I understand the information in my health record may include information relating to having sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected under federal privacy laws or regulations.

_____ I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice.

The identified information may be used by or released tot he following individual(s) or organizations

Name: Vascular Institute of Michigan
Address: 1325 S. Linden Rd. Flint MI 48532

Name: _____
Address: _____

This authorization will expire on (inser date or event) _____

If I fail to specify an expiration date or event, this authorization will expire Janualry 1st of every year.

_____ ____/____/____

Patient Signature (or signature of person completing form if not patient*) Date

*Relationship to patient ☐ Parent ☐ Legal Gaurdian ☐ other: _____

_____ ____/____/____

Witness Signature Date