Comprehensive Vascular and Endovascular Care
22250 Providence Drive, Suite 555
Southfield, MI 48075

26850 Providence Parkway, Suite 405
Novi, MI 48374

PERMISSION AUTHORIZATION WAIVER

Provided below are the name(s) of person(s) in which Comprehensive Vascular Care, PC has the authorization to discuss any of my medical records with, whether the office staff or physician calls my home and I am not at home, or if a family member(s) calls wanting to know about my medical condition. I also give the family members listed below permission to access my information via the Patient Portal.

Person to release information to:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

○ I DO NOT want to have my records, discussed with anyone but myself.

I have read all the information above and agree here within to the statement made. I agree to notify the Practice immediately, when changes are to be made to the above listed information.

_____ _____

Patient Name (Please PRINT) Patient Signature

_____

Date

Consistent with HIPAA, this information is updated annually