PREMIER VEIN & VASCULAR

(Choice Health Care, Inc.)
1881 West Kennedy Blvd., Suite A & B, Tampa, FL 33606
Corp: 515 Missouri Avenue North, Largo, FL 33770

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: ______________________________ **Birth Date:** ____________ **Age:** ________

Social Security Number: ______________________ **Sex: M / F**

To Facility/Entity: ____

Phone: ______________________________ **Fax:** ______________________________

INFORMATION REQUESTED:

- o ENTIRE MEDICAL RECORD
- o PSYCHIATRIC RECORDS

****If only a portion of the medical record or psychiatric record is required please specify****

- o Discharge Summary
- o Emergency Room
- o Laboratory Results
- o History & Physical
- o X-ray Reports
- o Immunization Records
- o Operative Reports
- o Progress Notes
- o HIV Test/Status
- o Nurses Notes
- o Radiology Film/Imaging CD-ROM
- o Other______________________________

Date(s) of Service Requested:

THE ABOVE RECORD IS TO BE RELEASED TO THE FOLLOWING VIA FAX: (855) 861-0819

Choice Health Care, Inc. d.b.a. Premier Vein & Vascular

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that id the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described about may be re-disclosed and no longer protected by these regulations I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature: ______________________________________ **Date:** ____________________

Printed Name: ___________________________________ **Date:** ____________________

Relationship to Patient: ____