BLOOMFIELD
VEIN & VASCULAR, PLLC

Release of Information

1. Authorization
   I authorize **Bloomfield Vein & Vascular** to disclose the protected health information described below to the following individuals (include name and address):

_____

_____

_____

2. Effective Period
   This authorization for release of information covers the period of healthcare from:
   A. (___)(initials) _____ to _____
   OR
   B. (___)(initials) all past, present and future periods.
3. A. (___)(initials) I authorize the release of my complete **Bloomfield Vein & Vascular** medical record
   OR
   B. (___)(initials) I authorize the release of only the following items from my **Bloomfield Vein & Vascular** medical record: _____
   _____
4. This medical information may be used by the person I authorize to receive this information for the following purposes:
   _____
   _____.
5. I understand that no alcohol or drug abuse records or HIV/AIDS information will be released unless I authorize the release of such information, below:
   A. (___)(initials) Yes, such records may be released.
   OR
   B. (___)(initials) No, do not release such records.
6. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
7. I understand that I have the right to revoke this authorization, in writing, delivered to **Bloomfield Vein & Vascular** at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
8. I understand that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient/Guardian Date

_____
Print Name

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