VITA
SURGERY | VASCULAR

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This document must be signed by the patient or person authorized by law.

I authorize _____ to release a copy of medical records for

_____ Name of Patient

_____ Date of Birth

_____ Social Security Number

_____ Other Identifying Information if applicable (other names)

Release medical records to:

_____ Name

_____ Address

_____ Address

_____ Phone

_____ Fax

I request a copy of my medical records (please check one and provide information needed)

___ I will pick-up my records from your office

___ Mail records to me at _____

___ Email my records to me at _____

___ Fax my records to me at _____

This information will be used on my behalf for the following reason(s): _____

_____

By initialing the spaces below, I authorize the release of the following records, if such exist:

___ Complete medical record (all information). The recipient understands that the entire record may be large and agrees to pay all reasonable copy charges.
___ Transcribed records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)
___ Laboratory reports
___ Pathology Reports
___ Diagnostic imaging reports
___ Billing statements
___ Physician office/clinical records
___ Photographs
___ This authorization is limited to the following treatment

_____

___ This authorization is limited to treatment for worker's compensation injuries of

_____

_____ Date

_____ Signature of Patient or Person Authorized by Law