AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: _____ **Phone**: _____

SSN: _____ **DOB**: _____

Address: _____
Street *City* *State* *Zip Code*

I, _____, authorize Wisconsin Vein Center & Medipa, S.C. to use or disclose my medical records to:
Patient Name

Destination of Medical Records:

Name: _____

Address: _____
Street *City* *State* *Zip Code*

Reason for record request: _____ Continued Medical Care _____ Patient Copy _____ Other

Method of Release of Medical Records: _____Pick Up _____Mail _____Fax/Number

I understand that the information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality. I agree that a photocopy of this release shall be as valid as the original. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure, to those persons and/or agencies named above. I further release Wisconsin Vein Center & Medi Spa, S.C. and its employees from any legal liability arising from the disclosure of this information to such persons or agencies named above, provided the disclosure of this information is done substantially in accordance with applicable law.

Signature Authorization:

Patient/Guardian: _____ Signature Date: _____

Legal Representative:_____ Signature Date: _____

This consent is in effect until _____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.