

# TOTAL VEIN CARE

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Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name	Date of Birth	Social Security Number	
Address	City	Zip	Phone

RELEASE FROM: [Name of physician or facility releasing information]			
I authorize release of my medical record from			
Physician/Facility			
Address	City	Zip	Phone

RELEASE TO: [Name of physician or facility receiving information]			
Please send my medical record to:			
Physician/Facility			
Address	City	Zip	Phone

RELEASE INFORMATION			
Reason: <input type="checkbox"/> Change of insurance	<input type="checkbox"/> Transfer of care	<input type="checkbox"/> Personal file	
<input type="checkbox"/> Moving out of area	<input type="checkbox"/> Specialist consultation	<input type="checkbox"/> Legal	

Please release the following (check all that apply)

RECENT H&P	LAST THREE VISITS
LAB REPORTS	X-RAY REPORTS
HOSPITAL REPORTS	OTHER:

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

### CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/HTLV/AIDS test results.

I understand that I may be charged for copies provided. (See reverse side.)

YES   NO   Initials


Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.