



Internal Use Only | Account # _____
Pickup Instructions _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME:		
	DOB: / /		PREVIOUS NAME(S):
2. RELEASE MY RECORDS FROM	FACILITY NAME:		
	DR. NAME:		
3. SEND MY RECORDS TO	NAME:		ATTN TO:
	ADDRESS:		
	CITY:	STATE:	ZIP:
	PHONE:		FAX (For Continuing Care ONLY):
	UPCOMING APPT DATE: ___ / ___ / _____		
4. TYPES OF RECORDS	BODY PART:		
	DATE(S) OF SERVICE:		
	<input type="checkbox"/> Office Notes <input type="checkbox"/> Billing Statement <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Operative Note <input type="checkbox"/> All Health Records (not including billing or imaging) <input type="checkbox"/> Other _____		
5. VERBAL DISCLOSURE	For verbal disclosure, check here: _____		
	"Verbal disclosure" authorizes VIE to discuss my care with the person(s) indicated in this section:		
6. REASON FOR REQUEST	<input type="checkbox"/> Personal Use <input type="checkbox"/> Insurance <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Legal <input type="checkbox"/> Continuing Care		
	Do you need imaging on a CD? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. RETURN COMPLETED FORMS TO:	MAIL TO: Vascular & Interventional Experts 4100 Minnesota Dr #310 Edina, MN 55435		EMAIL TO: FAX TO: 952-838-0651 DROP OFF: Vascular & Interventional Experts
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.		
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	<ul style="list-style-type: none"> I may revoke this authorization at any time by notifying the facility identified above in writing. By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. There may be a fee for release of this information and I may be responsible for that fee. I am authorizing the release of my personal protected health information to and from the entities I've indicated above Treatment will not be denied to me if I do not sign this form. This authorization will expire one year from the date I sign on this form. <p>SIGNATURE: _____ DATE: _____</p> <p>PRINT NAME: _____</p> <p><small>*If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.</small></p>		