Authorization For Release of Information

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

1. I hereby request and authorize NJ Vein Care to release information from the health record(s) of:

Patient's Name____ Patient's Date of Birth_______________________________

Patient's Social Security Number_________________________________

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).

2. The requested information is to be sent to (name of doctor, hospital, person or organization where records should be sent):

Name: ____

Address: ____

Business Phone:__________________________________ Fax:____

3. The information to be released is the notes, testing and reports generated by NJ VeinCare:

4. Purpose/reason for release of records (circle): Insurance / Legal Matters / Marketing / Fundraising
Other (explain): ____

5. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

6. I understand that my treatment is not conditioned on obtaining this authorization.

7. I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.

8. I understand that information used or disclosed may no longer be protected by the federal privacy laws.

9. I understand that I can be charged for obtaining copies of my records according to the fee schedule established in the New Jersey Administrative Code.

10. If the requested information involves mental health information, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege.

11. I understand if this authorization is for marketing purposes that NJ Vein Care may receive direct or indirect compensation.

Printed Name of Patient: ____ Date: ________________

Signature of Patient: ____

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