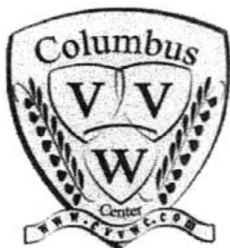

COLUMBUS VASCULAR VEIN & WOUND CENTER

895 S. State St
Westerville, OH 43081
http://www.cvvwc.com

phone: (614) 917-0696
fax: (888) 732-7890
email: info@cvvwc.com

Authorization to Release Medical Records

Name of Patient ______________________ Date(s) of Service ______________________

Date of Birth ______________________ Social Security Number ______________________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other ______________
Legal Purposes	School	______________

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray/Imaging Reports	Other ______________

The above information may be released:

To: Dr Pannu / Columbus Vascular Vein & Wound Center (614)917-0696

895 S. State Street, Westerville, OH 43081

From: ____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

____
Address (Street, City, State and Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to, history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

______________________________ ______________________
Signature (Patient or Legally Authorized Representative) Date

______________________________ ______________________
Printed Name Relationship to Patient