GRAND VEIN SPECIALISTS

Ever Clinic

Patients Name: _____ Date of Birth: _____

Authorization for Release of Patient Information

I hereby authorize that the protected health information regarding the above-named person be forwarded to Grand Vein Specialists, Ever Clinic

FROM:

Person/ Institution: _____

Address: _____

City: _____ State:_____ Zip code: _____

Phone number: _____ Fax number: _____

☐ Entire Medical Record ☐ Laboratory Results ☐ Imaging Reports

☐ Emergency Room (Facesheet,Discharge Summary. H&P and any test results)

☐Other _____

Treatment/ Service date(s) _____

I understand that:

- ➔ The information in my health record may include information relating to ecually transmitted deseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and or drug abuse.
- ➔ I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. This authorization shall remain valid unless revoked but will expire 1 year after signing.
- ➔ Revocation will not apply to information that has already been released in response to this authorization
- ➔ Once the above authorization is disclosed, there is a possibility that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
- ➔ Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that; therefore, my request may not be honored.
- ➔ Authorization to use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Pay or eligibility for benefits

_____ _____

Patient/ Legal Guardian Signature Date

4952 W. Irving Park Rd.
Chicago IL. 60641

6227 Cermak Rd
Berwyn IL. 60402

1508 Grand Ave
Waukegan IL 60085

Phone: (773)942-6141

Email: Receptionist@gvsmed.com

Fax:(866) 707-2267