MONTEREY BAY VASCULAR

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____ ***USE AND***

DISCLOSURE OF HEALTH INFORMATION

I hereby authorize MONTEREY BAY VASCULAR, INC to release to:

(*Persons/Organizations* authorized to receive the information

_____

(*Address* – street, city, state, zip code) (Phone) (Fax)

_____

The following information:
☐ All health information pertaining to my medical history, mental or physical condition and treatment received; OR
☐ Only the following records or types of health information:

_____

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request; OR ☐Other:

_____

EXPIRATION

This authorization expires on (date): _____

MY RIGHTS

• I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
• I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
• I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Pedes Orange County, 4501 Birch Street, Newport Beach, CA 92660 OR Fax: 949-209-0407
• I have a right to receive a copy of this authorization

SIGNATURE

Signature: _____ Date: _____
(patient/legal representative)
If signed by a person other than the patient, indicate relationship: _____

Print name: _____
(legal representative)