SOUTH ATLANTA
VASCULAR INSTITUTE

Authorization for Release of Health Information

Patient Name: _____ Date: _____ /_____ /_____

Social Security Number: _____ /_____ /_____ Date of Birth: _____ /_____ /_____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ - _____

Information Needed:

Clinic Visits: _____ Ultrasound Report: _____ Operative Reports: _____ Entire Chart: _____

I would like this information released by: Mail: _____ Fax: _____ Pick-up: _____

I hereby authorize South Atlanta Vascular Institute to release the protected health information regarding the above-named patient to:

Person/Institution:

_____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ - _____ Fax Number: (_____) _____-_____

Re-Disclosure: State and Federal regulations prohibit the disclosure of alcohol and drug testing, HIV, ARC and AIDS regulated diagnosis without specific written permission. Additionally, re-disclosure of the requested health information is specifically prohibited by the recipient. South Atlanta Vascular Institute cannot

guarantee that the recipient will not re-disclose the requested health information to others.

Patient or Representative signature:

_____

Relationship to the Patient:

_____

Witness signature:

_____