Vein Treatment Institute

of Bucks County

David N. Brotman, M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: ______________________ Date of Birth: ____________

Person(s)/organizations authorized to use/disclose information from:

____

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____

Person(s)/organizations authorized to receive the information:

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Information that may be used/disclosed:

☐ **Record of all visits** or:

☐ Discharge Summary ☐ Operative Report(s) ☐ X-Ray, MRI, CT, US

☐ Consultation Report(s) ☐ Progress Notes ☐ Laboratory Report(s)

☐ Statement of Charges/Payments ☐ AIDS or HIV Info.

SECTION B: Must be completed only if a health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

   a. The information will be used /disclosed for the following purposes:

   ○ Continued Patient Care ____________ ○ Attorney/Legal ____________
   ○ Disability Determination ____________ ○ Insurance Claim ____________
   ○ Personal Use ____________ ○ Other ____________

   b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ____ Yes ____ No

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

3. I understand that I may inspect and copy any information to be used or disclosed.

SECTION C: Must be completed for all authorizations.

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

______________________ ____________

Signature of Patient or Representative Date

______________________ ____________

Printed Name of Patient's representative (if applicable) Relationship to Patient