



Authorization of Release of Information to Family and/or Friends

Name of Patient: _____ Date of Birth: _____

I authorize Vein Center for Excellence of Des Moines, to release protected health information to the entities named below:

Give information to spouse/partner: Yes No N/A

Name of spouse/partner: _____

Give information to a family member or friend, please list: _____

Primary Contact Number: _____

Contact me at work: Yes No N/A

Leave message at work: Yes No N/A

Leave message at home: Yes No N/A

Description of Information to be released to family or friend:

Financial/Billing: Yes No

Medical Information: Yes No

Please list any restrictions regarding information to be released: _____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Vein Centers for Excellence of Des Moines. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective immediately upon receipt of notification by Vein Centers for Excellence of Des Moines.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

Date: _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)