AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Other Name Used: _____ Social Security #: _____

I request and authorize _____

release healthcare information of the patient named above to:

Name: DESERT VEIN AND VASCULAR INSTITUTE

Address: 14155 N 83RD AVE. STE 136

City: PEORIA State: AZ Zip Code: 85381

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates: _____

_____

□ All healthcare information

□ Other: _____

Patient Signature: _____ Date Signed: _____

WE REQUIRE AN UPDATED AUTHORIZATION EVERY 90 DAYS

Desert Vein & Vascular Institute
14155 N 83rd Ave Suite 136 Peoria, AZ 85381
Phone: 623-847-3884
desertveinandvascular.com