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AUTHORIZED INFORMATION RELEASE FORM

Patient Name: _____
Social Security Number: _____

Any physician, staff, employee or representative of Birmingham Vascular Associates, P.C. Has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number (s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect y access to treatment. I can refuse to sign this form. I can revoke it by writing to Birmingham Vascular Associates, P.C. Or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that this information is shared by the above individuals and it may be subject to re-disclosure by the individual(s).

Patient Signature: _____Date:_____

Copy given to patient