AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

VASCULAR SPECIALISTS OF MOBILE, P.C.

Patient:_____ **Date of Birth:**_____

Address:_____ **SSN:**_____

_____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed must be identified in a specific and meaningful fashion; and must reveal the purpose of the use and disclosure. Please check all that apply:

_____**Medical information** _____**Financial Information (pertaining to medical history)**

_____**Demographic Information** _____**Insurance Information**

_____**Other (please specify)** _____

Individuals to whom information can be released (OTHER THAN THOSE REQUIRED BY LAW):

(Please identify by name)

_____

_____

_____

_____

Expiration Date: _____**Indefinitely (no expiration date)**

_____**Other (specify)**

_____

_____

_____ **Date**_____

Patient Signature (or Personal Representative)