Fayetteville Vascular and Vein Center, P.A

Michael A. Leke
American Board of Surgery Certified
Vascular and Endovascular Surgery

INFORMATION RELEASE AUTHORIZATION

Name: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize Fayetteville Vascular and Vein Center, P.A. to ☐ Obtain from the following

☐ Release to the following

Medical Practice/ Hospital Name: _____

Address: _____ City_____ State____ Zip Code _____

Telephone: _____ Fax: _____

The request and authorization applies to:

☐ All health care information

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

_____

☐ Other: _____

I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it.

I understand that my authorization will remain effective from the date of my signature until _____ and that the information will be handled confidentially in compliance with all applicable federal laws.

I authorize transmittal of this information by fax and release you from liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by fax.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Name of Authorized Representative