



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient

1. _____
Name, Last, First, MI *Date of Birth*

_____ *Street Address* _____ *City, State, Zip*

2. **Authorize Records Released From:** _____ **To:** _____
Name Wisconsin Vein Center & Medi Spa
_____ 1231 George Towne Dr Suite G
Street Address Pewaukee, WI 53072
_____ Ph: (262) 746-9088 / Fax: (262) 746-9087
City, State, Zip

3. **Type or extent of information to be released: (check all applicable categories)**

- | | |
|--|---|
| <input type="checkbox"/> Medical history, exam reports | <input type="checkbox"/> Lab reports |
| <input type="checkbox"/> Operation reports | <input type="checkbox"/> Treatment or tests |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> X-Ray reports |
| <input type="checkbox"/> Hospital records, including reports | <input type="checkbox"/> Ultrasound Imaging |

4. **Purpose or need for release:** _____

I understand that the information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality. I agree that a photocopy of this release shall be as valid as the original. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure, to those persons and/or agencies named above.

Signature Authorization:

Patient/Guardian: _____ Signature Date: _____

Legal Representative: _____ Signature Date: _____

This consent is in effect until _____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

