wisconsin vein center
& medispa

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:**

_____
Name

_____
Street Address

_____
City, State, Zip

To:

Wisconsin Vein Center & Medi Spa

1231 George Towne Dr Suite G

Pewaukee, WI 53072

Ph: (262) 746-9088 / Fax: (262) 746-9087

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

____ Medical history, exam reports
____Operation reports
____Consultations
____Hospital records, including reports
____Lab reports
____Treatment or tests
____X-Ray reports
____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.