wisconsin vein center
&medispa

## AUTHORIZATION FOR RELEASE OF INFORMATION

**Patient**: _____ **Phone**: _____

**DOB**: _____

**Address**: _____
*Street* *City* *State* *Zip Code*

I, _____, authorize Wisconsin Vein Center & Medipa, S.C. to use or disclose my medical records to:
*Patient Name*

**Destination of Medical Records:**

**Name**: _____

**Address**: _____
*Street* *City* *State* *Zip Code*

**Reason for record request**: _____ Continued Medical Care _____ Patient Copy _____ Other

**Method of Release of Medical Records**: Pick Up _____ Mai l_____ Fax/Number _____
or Email Address: _____
(Our office does not have encrypted email. Please be aware any emails sent are unsecured)

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

____ Medical history, exam reports
____Operation reports
____Consultations
____Ultrasound Imaging
____Lab reports
____Treatment or tests
____X-Ray reports
____Photos of Treatments

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. I further release Wisconsin Vein Center & Medi Spa, S.C. and its employees from any legal liability arising from the disclosure of this information to such persons or agencies named above, provided the disclosure of this information is done substantially in accordance with applicable law.

**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.