



CVR Verification Recv'd: _____ By: _____

- Medical Record Number: _____

- Birth Date: _____

- Location: _____

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION (PHI)

Patient Name (First, Middle, Last)

Birth Date - (MM/DD/YYYY)

Last (4) Digits of Your:

-Drivers Lic -or- - Soc Sec#

(Previous / Maiden Name?)

I. RELEASE INFORMATION FROM:

RELEASE INFORMATION TO:

(Select Only One / Separate Requests Required)

CVR - Location: _____

Other (Enter Provider Name, Specialty, Address, Phone / Fax)

(Select Only One / Separate Requests Required)

CVR - Location: _____

Patient Other (Enter Prov. Name, Specialty, Address, Phone / Fax)

II. PURPOSE OF RELEASE REQUEST?

- Patient Request (Copy or Review) - Permit _____ to be present during encounter

- Treatment / Care - Legal / Atty - Other (Specify): _____

III. INFORMATION TO BE RELEASED - (Records, Timeframe Media and Delivery Method):

I hereby authorize CVR to disclose and release the following types of health information:

Medical Records - (mark the record type below)

Operative / Surgical Notes - Only

Office Visits - Consult / Follow-up - Only

Billing Records

Ultrasound Interpretations - Only

Other (Specify): _____

Dates of Services - (MM / DD / YYYY)

From:

To:

Provide PHI on - (Select One)

Delivery PHI By - (Select One)

- Paper -or-

-Mail -or- -Fax -or- -Secure Email -or- -CVR Patient Portal

- Digital CD (Add \$25)

Email or Fax: _____

IV. **RELEASE AUTHORIZATION:** By my signature below, I affirm and authorize the disclosure of my protected health information as defined above. I understand that after CVR discloses my PHI it may no longer be protected by Privacy Law. I understand this *Authorization* is voluntary and I may revoke it by presenting my revocation in writing. This *Authorization* is valid for up to **180-days** beginning on the date affixed below. We are permitted up to 30-days to process record requests; records for treatment purposes can be faxed to the healthcare provider if requested. As permitted, CVR may collect a fee to reproduce your records; at a minimum, a processing fee of \$6.50 will be charged for non-provider records. Additional charges may apply.

Signature of Patient (or Personal Representative)

Date

Printed Name of Patient Personal Representative

Authority (Guardian, POA, Executor)

CVR USE: Delivery (How/Who/When):

Return Signed Authorization to:

CVR Medical Records Dept 7474 Greenway Center Drive, Suite 1000, Greenbelt, MD 20770

Email: medrec@centerforvein.com

Fax: (240) 473-4323

Questions? Contact CVR's Medical Record Dept at (240) 965-3890



PATIENT INSTRUCTIONS FOR OBTAINING PHI / MEDICAL RECORDS

CVR Patient Portal (Internet) or Completion of Authorization for Release of PHI Form

Dear Patient:

If you are requesting access to or want a copy of your medical record, please read these instructions. Under the HIPAA Privacy Rules, the Center for Vein Restoration (CVR) must safeguard the use and disclosure of patient health information, called “Protected Health Information” or (PHI). CVR patients can access their PHI through CVR’s secure, **online Patient Portal** or by submitting a written **Authorization Request** (this form).

CVR Patient Portal	Access: https://www.nextmd.com/ud2/Login/Login.aspx ; Logon; Click ‘My Chart’ (Header) and then ‘Request Health Records’.
Authorization to Release PHI Form	If not obtained through the Portal, <u>CVR requires your written authorization</u> prior to the release of PHI unrelated to ‘treatment, payment or health care operations’ or otherwise required.

PATIENT INSTRUCTIONS: Please complete the Authorization to Release PHI Form as directed below.

Step 1: For verification purposes, please enter your: Full Name (First, Middle, Last), Birth Date and the Last four (4) Digits of either your *Driver’s License* or *Social Security* number at the top of the form.

Step 2 - Complete Section I: Define where PHI is to be ‘Released From’ and ‘Released To’.

Reason for Request? “You want to...”	↓ (Check Box) Release Data FROM	↓ (Check Box) Release Data TO
Copy your patient records	<input type="checkbox"/> CVR – Location:	<input type="checkbox"/> Patient (Enter Address and Phone #)
Have CVR records sent to another entity/provider	<input type="checkbox"/> CVR – Location:	<input type="checkbox"/> Other (Enter Destination: Provider Name, Specialty Address, Phone & Fax)
Have records from another provider sent to CVR	<input type="checkbox"/> Other (Enter Source: Name, Specialty, Address, Phone& Fax)	<input type="checkbox"/> CVR – Location: (List your treatment Center Location – [City])

Step 3 - Complete Section II: Please indicate the purpose/reason for the release request (*choose only one*). This form will also be used if the patient requests/requires another person to accompany them during an encounter (i.e., Personal Repr., Caregiver or Interpreter). Enter the person’s name after ‘Permit _____’. If the reason is not indicated, please select ‘Other’ and write-in the reason.

Step 4 - Complete Section III: Specify the record detail – (Record type, Timeframe, Media and Delivery).

- **Record Type:** Check the box next to the record types you would like. (*select all that apply*)
- **Timeframe:** Define the ‘From’ and ‘To’ dates – Please use the date format (MM / DD / YYYY).
- **Media:** CVR can provide paper records or electronic versions on a CD. (*select only one*)
- **Delivery Method:** Define how you would like to receive the records. (*select only one*)

Step 4 – Sign-off on Section IV: Please read the ‘Release Authorization’ to understand your rights and specifics of the record release. The Patient must sign and date where indicated; if a Personal Representative or other caregiver is involved, please print their name on the second line and define the basis for their authority to act on the patient’s behalf. State laws permit the collection of ‘reasonable costs’ for record production, shipping or handling fees prior to the release of records.

Submit – Return Signed Authorization to CVR: Hand-deliver, Mail, Email or Fax the Authorization to:

CVR Medical Record Dept.
7474 Greenway Center Drive, Suite 1000, Greenbelt, MD 20770-3500
Email: medrec@centerforvein.com **Fax:** (240) 473-4323

Questions? Contact CVR’s Medical Record Dept at (240) 965-3890