Center for Vein Restoration

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION (PHI)

CVR Verification ***Recv'd:*** ______________ ***By:*** _____
- Medical Record Number:
- Birth Date:
- Last 4 Digits: ☐-SS# or ☐-Driver Lic-ID

Patient Name *(First, Middle, Last)*	**Birth Date *(MM/DD/YYYY)***	**Last (4) Digits of Your:** ***☐-Drivers Lic - or - ☐- Soc Sec#*** ____ ____ ____ ____

I. RELEASE INFORMATION FROM:

☐ **CVR – Medical Records Dept**
☐ **Other - (Provide: Name, Address, Phone and Fax)**

____
____
____
____
____

RELEASE INFORMATION TO:

☐ **CVR – Attn:** ______________________________
☐ **Patient - (Provide: Name, Address and Phone below)**
☐ **Other - (Provide: Name, Address, Phone and Fax below)**

____
____
____
____

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)*	☐ Billing Records
☐ *Office Visits – Consult / Follow-up - Only*	☐ Other (Specify):
☐ *Ultrasound Interpretations - Only*	
☐ *Operative / Surgical Notes – Only*	

Dates of Services - *(MM / DD / YYYY)*	**From:**	**To:**

Provide PHI on - *(Select One)*	**Delivery PHI By - *(Select One)***
☐ **- Paper** ***-or-***	☐-Mail *-or-* ☐-Pick-Up *-or-* ☐-Fax *(Print address, email or fax below)*
☐ **- Digital Format** *(Add $10)*	☐-Patient Portal *-or-* ☐-Encrypted Email *-or-* ☐-Mail *(Print email address or fax number):*

IV.

RELEASE AUTHORIZATION: By my signature below, I affirm the authority to sign and authorize the disclosure of my protected health information as defined above. I understand that after CVR discloses my PHI *(in paper or electronic format conveyed by hand, mail, email or fax)* it may no longer be protected by Privacy Law. I further understand this Authorization is voluntary and I may revoke it by presenting my revocation in writing. This Authorization is valid for up to 180-day period beginning on the date affixed below. Most State laws permit up to 30-days to process record requests, however records for treatment purposes can be faxed to the patient's healthcare provider when requested. As permitted by State law, CVR may collect reasonable costs to reproduce your records (a cost estimate will be provided prior to record release).

______________________________________ ______________________
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 20770-3500
Email: medrec@centerforvein.com ***Fax:*** (240) 473-4323
Questions? Contact CVR's Medical Record Dept at (240) 965-3200 – (option #2)

INSTRUCTIONS FOR COMPLETION OF CVR's

Authorization For Release of Patient Protected Health Information (PHI)

If you are requesting access to your medical record or to get a copy of your health information, please read these instructions. Under the Federal HIPAA Privacy Rules all healthcare providers must safeguard the use and disclosure of patient health information—called "Protected Health Information" (PHI). **To comply with HIPAA, CVR requires your written authorization prior to the release of PHI that is not for 'treatment, payment or health care operations' or otherwise required.**

PATIENT INSTRUCTIONS: Please complete the *Authorization to Release* form as directed below.

A. 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.

B. Section I: Please define where the information is to be 'Released From' and 'Released To'. Use the table below to assist your selection.

Reason For Request? *"You want to…"*	↓ *(Check Box)* **Release Data FROM**	↓ *(Check Box)* **Release Data TO**
Copy your patient records	☐ **CVR – Medical Records Dept**	☐ **Patient** *(Write Your Address and Phone Number)*
Have CVR records sent to another entity/provider	☐ **CVR – Medical Records Dept**	☐ **Other** *(Write Destination: Name, Address, Phone& Fax)*
Have records from another provider sent to CVR	☐ **Other** *(Write Source: Name, Address, Phone& Fax)*	☐ **CVR – Attn: __** *(List CVR Center Location or Provider - if known)*

C. 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 Representative, Caregiver or Interpreter). Write the person's name after 'Permit _____'. If the reason is not indicated, please select 'Other' and write-in the reason.

D. Section III: Please specify the records requested – (Record type, Timeframe, Media and Delivery).

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

E. Section IV - PATIENT AUTHORIZATION: Please read the 'Release Authorization' to understand your rights and specifics of the record release. The patient (or Personal Representative) must sign and date where indicated. If there is a Personal Representative or other caregiver involved, please print the name of that individual on the second line and define the basis for their authority to act on the patients behalf. Please note that State laws permit the collection of 'reasonable costs' for record production, shipping or handling fees prior to the release of records (C*VR will provide a cost estimate prior to record release).*

F. ***Return Signed Authorization to CVR:*** You can hand-deliver, mail 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) 965-3200 – (option #2)