

HIPAA AUTHORIZATION

I understand that I am giving authorization to Dallas Vein Specialists (and/or its designated record/database custodian) to release and disclose my protected health information. This information may relate to my past, present, or future payment for the provision of health care to me.

I may revoke this authorization at any time by notifying in writing of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by Dallas Vein Specialists before receipt my written notice of revocation. And, I also understand that my revocation may not be honored if Dallas Vein Specialists have taken action in reliance upon my signed Authorization Form.

I understand that I may inspect and receive a copy of the protected health information to be released and disclosed pursuant to this Authorization Form. By signing this form below, I acknowledge that my signature is voluntary and I understand that I am not required to sign this form in exchange for receiving health care treatment.

A photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original. If the patient is a minor, is incapacitated, or is deceased, then the signature of the guardian or representative shall be considered as effective and valid.

Signature of Patient (or Guardian/Representative)

Date

Printed Name of Patient (or Guardian/Representative)

Date