MIDWEST AORTIC & VASCULAR INSTITUTE P.C.™

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

Patient Name: _____
Last First MI Maiden/Other Name

Date of Birth: _____/_____/_____ Last 4 of Social Security Number: _____

Address: _____ City: _____ State: ____ Zip: _____

Day Phone: _____ Evening Phone: _____

With your permission, Midwest Aortic & Vascular Institute, P.C. may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, Midwest Aortic & Vascular Institute, P.C. may tell a family member when your next medical appointment is scheduled, the results of a laboratory test or a procedure, or provide the person with a copy of a prescription. By completing the top portion of this form, you are authorizing release of this information to these individuals. However, you are not authorizing Midwest Aortic & Vascular Institute, P.C. to provide extensive information about your medical history or copies of information from your medical record. Please be aware that Midwest Aortic & Vascular Institute, P.C. may use professional judgment in determining the amount of information to disclose. Please identify the person or persons who are involved in your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name: _____ Relationship: _____ Date of Birth: _____

Name: _____ Relationship: _____ Date of Birth: _____

I understand that if I change my mind about any of the information on this form, I must contact Midwest Aortic & Vascular Institute, P.C. to revoke this form in its entirety or to complete a new form.

_____ _____
Signature of Patient/Guardian/DPOA Date