



MIDWEST
AORTIC &
VASCULAR
INSTITUTE
P.C.™

2750 Clay Edwards Drive, Suite 304 • North Kansas City, MO 64116
2521 Glenn Hendren Drive, Suite 112 • Liberty, MO 64068
4200 Little Blue Parkway, Suite 350 • Independence, MO 64057
Phone 816.842.5555 • Fax 816.659.9123 • www.mavi.life

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

Robert R. Carter, MD, FSVS, FACS, RPVI • Michael K. Deiparine, MD, FSVS, FACS • Scott W. Kujath, MD, FSVS, FACS • Karl R. Stark, MD, FSVS, FACS
Austin J. Wagner, DO, RPVI • Mike L. Waldschmidt, MD, FACS • Jonathan E. Wilson, DO, FSVS, RPVI • Annette Small, BSN, MBA – CEO
Stephanie Becker, PA-C • Vanessa Collins, FNP-BC • Jean Edmonds, ANP-BC, CWCN • Melissa Flood, FNP-C

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