1327 Ashley River Road, Charleston, SC 29407
Phone: 843-577-4551 ● Fax: 843-577-8868 ● www.coastalvvc.com

Authorization to RELEASE Protected Health Information

Patient Name: ____ **Date of Birth:** _____________________

Phone #: ______________________________ **Social Security #:** _______________________________

Address : ____

Release records from:

Coastal Vascular and Vein Center
1327 Ashley River Rd.
Charleston, SC 29407

Fax Completed form to: 843-577-8868 or Email to: jeanette.shelton@coastalvvc.com

Send records to: ____
Name of Practice or Doctor

____
Street Address

____
City, State, Zip Code

__________________________________ __________________________________
Phone # **Fax #**

*****Please send: ______ Records ______ Imaging***

Sensitive Information: I understand that my record may include information relating to acquired immuno-deficiency syndrome (AIDS), or HIV (Human Immuno-deficiency) Infection, psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.

Expiration: I understand that this authorization will expire 12 months after signed unless an earlier date is specified.
Date specified:

I authorize Coastal Vascular and Vein Center to release all my protected health information.

____ ________________________
Signature of Patient or Legal Representative **Date**

____
Description of Legal Representative's Authority