



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@stridecare.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