ADVANCED VASCULAR ASSOCIATES

AdvancedVascular.com

Main Phone: 973-540-9700
Fax: (973) 540-9717

Name: ______________________________ **Date of Birth:** ______________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Release Information From: Medical Facility (Name, Address, Phone):	Release Information To: **ADVANCED VASCULAR ASSOCIATES** 131 Madison Avenue, Second Floor Morristown, New Jersey 07960

PURPOSE OF RELEASE: ☑ Treatment / Continued Care

INFORMATION TO BE RELEASED:

REQUIRED - Please specify from below list or select entire medical chart

- ☐ Radiology Images and Reports
- ☐ Operative Reports
- ☐ Emergency Room Record
- ☐ Medications
- ☐ Ultrasound Images and Reports
- ☐ Clinical Notes
- ☐ Discharge Summary
- ☐ Entire Medical Chart
- ☐ Laboratory Reports
- ☐ Cardiology Testing
- ☐ Billing Record
- ☐ Other

PHARMACY/MEDICATION HISTORY

I authorize Advanced Vascular Associates to obtain all of my medication history, as is medically necessary, in any format, to provice my medical care.

SIGNATURE (REQUIRED)			DATE SIGNED (REQUIRED - MONTH DD, YYYY)
PRINTED NAME OF PERSON SIGNING (IF NOT PATIENT)			RELATIONSHIP
MAILING ADDRESS OF PATIENT - STREET			
CITY	STATE	ZIP CODE	PHONE

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

With my consent, Advanced Vascular Associates, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Vascular Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Vascular Associates, 131 Madison Avenue, Second Floor, Morristown, New Jersey 07960-7360.

With my consent, Advanced Vascular Associates may call, e-mail, or mail to my home or other designated location and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Advanced Vascular Associates may call, e-mail, or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and to receive free health resources and periodic special offers from our offices.

By signing this form, I am consenting to Advanced Vascular Associates' use and disclosure of my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO).

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Advanced Vascular Associates may decline to provide treatment to me.

Is there a person that you authorize to receive/discuss your PHI? ☐ Yes ☐ No

If yes, please indicate name and relationship: ____________________

Special Instructions: ____________________

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Patient's Names (print) Date

____________________ ____________________

Parent/Legal Guardian Name (print) Siganture of Patient or Legal Guardian