Vascular Center of the Midwest
Excellence in Comprehensive Vascular Care

HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize Vascular Center of the Midwest (VCM), LLC., to obtain from the following or release to the following of protected health information about me as described below.

1. **The following specific person/entity is authorized:**

   _____

2. **The following persons (or class of persons) are authorized:**

   Medical Practice/Hospital/Health Care Entity Name

   Address

   City, State Zip Code **Telephone** **Fax**

3. **The specific information that should be disclosed is (please give dates of service if possible):**

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

4. **I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.**
5. **I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.**
6. **This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.**

A copy of this completed, signed and dated form must be given to the Individual or other authorized individual.

Signature of Patient or Guardian* or Personal Representative of Patient's Estate	**Date of Patient's or Guardian's/ Personal Representative's Signature**	**Description of Authority to Act for the Individual**