# Patient and Guardian Consent and Release

Date: _____ Patient Acct #: _____
Name: _____ Date of Birth: _____
Gender: _____ Social Security: _____
Preferred Language: _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American

□ White □ Native Hawaiian or Other Pacific Islander

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

*Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled. You may request a copy of the policy from our staff. Please read each authorization carefully and indicate your approval by initialing on the lines provided.*

I authorize the release of all medical records maintained by the Vein Centre, which relate to services I have received from, or the results of test ordered by the Vein Centre. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and/or a third party liability claim.

I authorize the Vein Centre to obtain my prior films, scans, labs, and any records including demographic, pharmacy and medication history that may identify me and that relates to my past, present, and/or future physical or mental health or condition and related health care services. I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of The Vein Centre to obtain my prior films, labs, and/or other records, I am giving my permission to call and/or fax on my behalf in order to get needed medical records and films.

I authorize direct payment of benefits from my insurance plan to the Vein Centre. I understand that I am responsible for payment of professional fees charged by the Vein Centre, which are not covered or not properly reimbursed under the terms of my insurance plan.

I will provide the Vein Centre, with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voice mail and/or an answering machine to convey information regarding my care. Contact via e-mail is authorized, if I provided my e-mail address to the Vein Centre.

I authorize the use of faxing or email to send my information to myself or to other parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when faxing or email is used.

I understand that it is my right to request limited access to my records and to withdraw permission for the release of my records. I understand that this request must be in writing and that limiting or withdrawing my permission may result in the Vein Centre, discontinuing its relationship with me and that I will need to seek care from another source.

I understand that photography is a a necessary part of planning and evaluating vein surgery. I authorize that the taking of photographs and the release of such photographs at the direction of my surgeon and under such conditions as may be approved by him. These photographs will be used solely for documentation purposes and will be kept confidential.

Relationship: (Circle one) Self Parent Guardian

Patient Signature _____Date: _____

I have been offered a copy of The Surgical Clinic Notice of Privacy Policy for my own records. Initial: _____