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Practice Website: www.vgssofswfl.com

Request: To Obtain Medical Records From

By signing this authorization, I authorize *Vascular & General Surgical Specialists of SWFL* to use and/or obtain certain protected health information (PHI) about me from the party or parties listed below.
Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____Fax:_____ Attn: _____

The following individually identifiable health information (PHI)
(Specifically describe the information to be obtained, such as date(s) of service, level of detail to be obtained, origin of information, etc.)

- ☐ All Records: From_____To_____
- ☐ Discharge Summary
- ☐ Emergency Records
- ☐ Dictated Consults
- ☐ Physicians Orders
- ☐ Progress Notes
- ☐ Other _____
- ☐ Specific Request
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ EKG Reports

I authorize the following (PHI) information to be released: Please put your initials on next line below:
_____ (Patient initials) Hepatitis C Records, HIV/AIDS Records, Psychiatric / Psychological information/records, Drug/alcohol Treatment

The information will be used or disclosed for the following purpose:
For Continued Medical Care at Vascular &General Surgical Specialists of SWFL

This authorization to obtain records will expire on _____. If an expiration date is not written it will expire one year from the date signed below.
The purpose(s) is/are provided so that I can make an informed decision whether to allow the information to be obtained. I do not have to sign this authorization in order to receive treatment from Vascular & General Surgical Specialists of SWFL. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient to a non covered entity and may no longer be protected by the federal HIPAA Privacy Rule. This authorization will expire one year from the date it was signed; However, I have the right to revoke this authorization in writing except to the extent that Vascular & General Surgical Specialists of SWFL has acted in reliance upon this authorization. My written revocation must be submitted to Security & Privacy Director at 13782 Plantation Rd, Unit 103, Fort Myers, Fl 33912.

Signed by:

_____	_____
Signature of Patient or Legal Guardian	**Date of Birth**
_____	_____
Patient's Name (Print)	**Social Security Number (Last Four)**
_____	_____
Witness	**Date**