Vascular Action, LLC
Dialysis Vascular Access Center

Baudouin Leclercq, MD
Timothy W. Rogers, MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

_____

to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Staff Witness: _____ Date Signed: _____

2810 W St. Isabel St., Suite 102
Tampa, FL 33607

Phone: 813-872-8480 **Fax: 813-872-8579**