Consent for Release of Medical Information

I hereby authorize the Vascular Center and Vein Clinic of Southern Indiana, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient Name: _____

Address: _____
(Street) (City) (State) (ZIP Code)

Date of Birth: _____

Date(s) of Treatment: _____

Release Information to: _____
(Name of individual or organization)

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization or outpatient care
_____ Drug and alcohol treatment care
_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*
_____ Emergency room visit
_____ Psychiatric care *requires special consent

I am requesting the following information to be released:

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)
_____ Entire medical record
_____ Other: _____Labs _____Slides ** _____X-rays**

I permit this confidential information be released for the following purpose:

_____ Continuing medical treatment _____ Litigation for review
_____ Insurance (company name): _____
_____ Other: Specify Reason: _____

_____(Signature of Patient)

**I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc. A request may take 30 working days to process. If you do not receive the records within 30 days, you should call Medical Records Department at 812-336-6008.