



**AUTHORIZATION FOR RELEASE  
OF INFORMATION TO FAMILY AND/OR FRIENDS**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize Vein Help of Charlotte, or Vein Help of the Triangle, (Vein Help) to release protected health information to the entities named below:

Give information to spouse:  Yes  No  N/A

name of spouse: \_\_\_\_\_

Give information to a family member or friend, please list: \_\_\_\_\_

Contact me at work:  Yes  No  N/A

**Description of Information to be released to family or friend:**

Financial/Billing:  Yes  No

Medical information:  Yes  No

Please list any restrictions regarding information to be released: \_\_\_\_\_

**Rights of the Patient:**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclose as described in this document by sending a written notification to Vein Help. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective immediately upon receipt of notification by Vein Help.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

Date \_\_\_\_\_

\_\_\_\_\_  
Description of Personal Representative's Authority (attach necessary documentation)