Heart Vein & Vascular LLC

Babak Alex Vakili M.D, F.A.C.C, F.S.C.A.I

Integrative Cardiovascular Clinic

2170 W State Road 434, Suite 190
Longwood, FL 32779
Phone: 407-990-1921 Fax: 855-537-4411
E-Mail: Support@heartveinvascular.com
Web: www.heartveinvascular.com

Patient Consent to Obtain Records

PATIENT NAME:____ DATE:__________

DOB:______________________ SOCIALSECURITY#__________________________

DO YOU LIVE IN AN ASSISTED LIVING FACILITY OR A NURSING HOME_____YES____NO

I AUTHORIZE THE FOLLOWING PHYSICIAN (S) AND/OR HOSPITAL (S) TO RELEASE MY RECORDS IN THEIR ENTIRETY OR AS INSTRUCTED BELOW, TO:

Heart Vein & Vascular LLC
2170 W State Road 434, Suite 190
Longwood, FL 32779
Tel: 407-990-1921
Fax: 855-537-4411
support@heartveinvascular.com

Heart Vein & Vascular LLC MAY ALSO ACCESS MY PATIENT PORTAL TO RETRIBVE NECESSARY RECORDS.

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PLEASE FAX RECORDS TO: 855-537-4411 (Heart Vein & Vascular LLC)

Purpose of Disclosure:

( ) Continuing care with another physician or hospital ( ) Personal copy ( ) Other:____________________

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving tile revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, or if I ask for it.
7. I will receive a copy of this form after I sign it.

Patient Signature:_____________________________________ Date:___________

Relationship to Patient____

Representative Signature:_________________________________ Date:___________