WEST COAST VASCULAR

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Authorization for Release of Medical Information

(1) The following request is being sent to: West Coast Vascular

(2) I _____, (patient or other legally authorized requestor),
Print Name

request the records of _____, born on _____ and
Print Patient Name Date of Birth

hereby authorize West Coast Vascular and any of his/her authorized agents under Part 2.6, Division 1 of the California Code to receive any and all medical information including but not limited to all information in the possession of the above named provider of health care regarding the medical history, mental or physical condition or treatment or a portion thereof as follows:

(3) Please select **one** of the following:

☐ Entire Medical Record;

☐ The last three (3) of the following (if present within the record: (1) Office visit notes; (2) Op Report(s); and (3) Ultrasound study(ies); **or**

☐ Other, please specify:_____

_____

(4) Please forward or release the requested records as specified above to:

(a) Patient: ☐ In Person Pickup (Acknowledment of Receipt_____)
☐ Mail to: _____
_____

(b) Physician Office: ☐ Fax to: _____
☐ Mail To: _____
_____
_____

This authorization shall remain in effect for an indefinite period, or until withdrawn by the patient. Any photocopy of this authorization shall be valid as the original.

I consent to this authorization and acknowledge information above.

_____ _____
Signature of Patient (Parent or Legal Guardian if patient is a minor or other legally authorized individual) Date

Please note: Any medical records requests by patients will be provided as soon as practicable and no later than allowed under applicable law. Records requested by patients to be sent to patients directly will be provided records within 15 days of the request.