VASCULAR SOLUTIONS, P.C.
VEIN & VASCULAR CENTER

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RELEASE OF MEDICAL INFORMATION

I authorize release of my medical information (medical records) to the **referring provider** (physician / nurse practitioner / physician assistant) who referred me to Vascular Solutions PC, if applicable.

☐ Yes ☐ No ☐ N/A

I authorize release of my medical information (medical records) to my **primary care provider** (physician / nurse practitioner / physician assistant), if applicable.

☐ Yes ☐ No ☐ N/A

I authorize release of my medical information (medical records) to **members of my care team** (external providers who are part of my existing care team), if applicable.

☐ Yes* ☐ No ☐ N/A

*List any specific providers to whom you would like your records forwarded:

_____

_____

_____

I authorize release of my medical information (medical records) to **external physician practices / medical facilities**, (if referral to another specialist or medical care institution is required)

☐ Yes ☐ No ☐ Decide later

Patient or Authorized Person:

Signature: Date: