

**AUTHORIZATION TO RELEASE
MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS**

In accordance with Federal Government Privacy Rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for Nelson Vein & Surgical Services to discuss your condition or appointments with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

_____ I authorize Nelson Vein & Surgical Services to take photos and publish them while maintaining my patient confidentiality.

_____ I do **not** authorize my photos to be published.

_____ I authorize Nelson Vein & Surgical Services to release any or all information concerning my medical care to anyone I list below.

_____ I do **not** authorize anyone to obtain medical information about me or my appointments.

Name

Relationship to the patient

Name

Relationship to the patient

Patients Name (print)

Patients Date of Birth

Patient Signature

Todays Date

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