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**