***Associates in Vascular Care***

## *Authorization to Release Medical Records:*

*I _____, authorize the office of Associates in Vascular Care to release*
*(Patient's Name)*
*any medical records to the following third party listed below.*

*Name of Facility(s) and/or Practice(s):*

_____

*Address:*

_____

*Phone Number & Fax Number:*

_____

*Medical records released from our office pertain to the following information:*
□ *Physician's Office Notes*
□ *Radiology or Ultrasound reports ordered by one of our physicians*
□ *Operative Reports*

*Signature:* _____
*(Patient or Representative)*
*Relationship to Patient:* _____

*Date:* _____