IVY
CARDIOVASCULAR
& VEIN CENTER

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS/DESIGNATED PERSON

Patient Name: _____ DOB: _____

Many of our patients allow family members such as their spouse, parents, or other designated persons involved in their care to call and request health and financial information. Under the requirements of HIPAA, IVY Cardiovascular & Vein Center and staff are not allowed to share your protected health information with anyone without your consent. If you wish to have your protected health information disclosed to family members or other designated persons, you must sign this form.

PLEASE CHECK ONE:

☐ I only want my medical information released to myself

☐ I give IVY Cardiovascular & Vein Center and staff authority to release protected health information to the following individual(s):

Name of Individual: _____

Relationship to Patient: _____

Name of Individual: _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF UNDERSTANDING

- I understand protected health information may include information regarding my diagnoses, treatment, test results, billing and insurance information.
- I understand this authorization will remain in effect as long as I am a patient of IVY Cardiovascular & Vein Center, unless I revoke this authorization in writing.
- I understand I have the right to revoke this authorization, in writing, at any time.
- I understand the information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA.

Patient Signature: _____ Date: _____