Center for Vein Restoration

CVR Verification ***Recv'd:*** _____ ***By:*** _____
- Medical Record Number:
- Birth Date:
- Location:

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION (PHI)

Patient Name ***(First, Middle, Last)*** (Previous / Maiden Name?)	**Birth Date -** ***(MM/DD/YYYY)***	**Patient Phone Number**

I. RELEASE INFORMATION FROM:

(Select Only One / Separate Requests Required)

☐ **CVR – Location:** _____

☐ **Other** *(Enter Provider Name, Specialty, Address, Phone / Fax)*

Name: _____

Address: _____

Phone: _____ Fax: _____

RELEASE INFORMATION TO:

(Select Only One / Separate Requests Required)

☐ **CVR – Location:** _____

☐ **Patient** ☐ **Other** *(Enter Prov. Name, Specialty, Address, Phone / Fax)*

Name: _____

Address: _____

Phone: _____ Fax: _____

II. PURPOSE OF RELEASE REQUEST?

☐ - Patient Request (Copy or Review) ☐ - Permit _____ to be present during encounter
☐ - Treatment / Care ☐ - Legal / Atty ☐ - Other *(Specify):* _____

III. INFORMATION TO BE RELEASED – *(Records, Timeframe Media and Delivery Method)*:

I hereby authorize CVR to disclose and release the following types of health information:

☐ Medical Records - *(mark ☑ the record type below)*	☐ *Operative / Surgical Notes – Only*
☐ *Office Visits – Consult / Follow-up - Only*	☐ Billing Records
☐ *Ultrasound Interpretations - Only*	☐ Other (Specify):

Dates of Services - ***(MM / DD / YYYY)***	**From:**	**To:**

Provide PHI on - ***(Select One)***	**Delivery PHI By -** ***(Select One)***
☐ **- Paper** ***-or-*** ☐ **- Digital CD** *(Add $25)*	☐-Mail ***-or-*** ☐-Fax ***-or-*** ☐-Secure Email **-or-** ☐-CVR Patient Portal *Email or Fax:* _____

IV.

RELEASE AUTHORIZATION: By my signature below, I affirm and authorize the disclosure of my protected health information as defined above. I understand that after CVR discloses my PHI it may no longer be protected by Privacy Law. I understand this *Authorization* is voluntary and I may revoke it by presenting my revocation in writing. This *Authorization* is valid for up to **180-days** beginning on the date affixed below. We are permitted up to 30-days to process record requests; records for treatment purposes can be faxed to the healthcare provider if requested. As permitted, CVR may collect a fee to reproduce your records; at a minimum, a processing fee of $6.50 will be charged for non-provider records. Additional charges may apply.

_____ _____
Signature of Patient (or Personal Representative) **Date**

_____ _____
Printed Name of Patient Personal Representative **Authority (Guardian, POA, Executor)**

CVR USE: Delivery *(How/Who/When):*

Return Signed Authorization to: CVR Medical Records Dept 7474 Greenway Center Drive, Suite 1000, Greenbelt, MD 20770
Email: medrec@centerforvein.com ***Fax:*** (240) 473-4323
Questions? Contact CVR's Medical Record Dept at (240) 965-3890

Center for Vein Restoration

PATIENT INSTRUCTIONS FOR OBTAINING PHI / MEDICAL RECORDS

CVR Patient Portal (Internet) or Completion of *Authorization for Release of PHI Form*

Dear Patient:

If you are requesting access to or want a copy of your medical record, please read these instructions. Under the HIPAA Privacy Rules, the Center for Vein Restoration (CVR) must safeguard the use and disclosure of patient health information, called "Protected Health Information" or (PHI). CVR patients can access their PHI through *CVR's secure, **online Patient Portal*** or by submitting a written ***Authorization Request*** (this form).

CVR Patient Portal	**https://www.medfusion.net/centerforveinrestorationmdllc-28001/portal/#/user/login** Logon; Click '"Ask a Question" to request medical records
Authorization to Release PHI Form	If not obtained through the Portal, CVR requires your written authorization prior to the release of PHI unrelated to 'treatment, payment or health care operations' or otherwise required.

PATIENT INSTRUCTIONS: Please complete the *Authorization to Release PHI Form* as directed below.

Step 1: For verification purposes, please enter your: Full Name (First, Middle, Last), Birth Date and Phone #.

Step 2 - Complete Section I: Define where PHI is to be 'Released From' and 'Released To'.

Reason for Request? *"You want to…"*	↓ *(Check Box)* **Release Data FROM**	↓ *(Check Box)* **Release Data TO**
Copy your patient records	☐ **CVR – Location:**	☐ **Patient** *(Enter Address and Phone #)*
Have CVR records sent to another entity/provider	☐ **CVR – Location:**	☐ **Other** *(Enter Destination: Provider Name, Specialty Address, Phone & Fax)*
Have records from another provider sent to CVR	☐ **Other** *(Enter Source: Name, Specialty, Address, Phone& Fax)*	☐ **CVR – Location:** *(List your treatment Center Location – [City])*

Step 3 - Complete Section II: Please indicate the purpose/reason for the release request *(choose only one)*. This form will also be used if the patient requests/requires another person to accompany them during an encounter (i.e., Personal Repr., Caregiver or Interpreter). Enter the person's name after 'Permit_____'. If the reason is not indicated, please select 'Other' and write-in the reason.

Step 4 - Complete Section III: Specify the record detail – (Record type, Timeframe, Media and Delivery).

- Record Type: Check the box next to the record types you would like. ***(select all that apply)***
- Timeframe: Define the 'From' and 'To' dates – Please use the date format **(MM / DD / YYYY)**.
- Media: CVR can provide paper records or electronic versions on a CD. ***(select only one)***
- Delivery Method: Define how you would like to receive the records. ***(select only one)***

Step 4 – Sign-off on Section IV: Please read the 'Release Authorization' to understand your rights and specifics of the record release. The Patient must sign and date where indicated; if a Personal Representative or other caregiver is involved, please print their name on the second line and define the basis for their authority to act on the patient's behalf. State laws permit the collection of 'reasonable costs' for record production, shipping or handling fees prior to the release of records.

Submit – Return Signed Authorization to CVR: Hand-deliver, Mail, Email or Fax the Authorization to:

CVR Medical Record Dept.
7474 Greenway Center Drive, Suite 1000, Greenbelt, MD 20770-3500
Email: medrec@centerforvein.com **Fax:** (240) 473-4323

Questions? Contact CVR's Medical Record Dept at (240) 965-3890