SOUTHERN VASCULAR CLINIC

5000 Ambassador Caffery Pkwy
Building 1, Suite 100
Lafayette, LA 70508
337-534-4444

Release of Medical Records

Last Name _____ First Name_____ DOB _____

Address _____ Address (additional) _____

Zip Code _____ City_____ State_____ Social Security #_____-_____-_____

Home Phone _____ Mobile Phone_____ Chart # _____

I hereby authorize _____ to release information from my medical records to ***Dr. Racheed J. Ghanami*** with ***Southern Vascular Clinic***.

Information to be released:

- o History and Physical
- o Progress Notes
- o Lab Reports
- o Diagnostic Imaging

Other: _____
_____
_____
_____

I understand that this authorization will expire one year after I have signed the form. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy Regulations. By authorizing this release of information, my health care, and payment for my healthcare will not be affected if I do not sign this form. I understand I may see and copy this form after I sign it. I understand that in compliance with Title 40 of Louisiana Administrative Code, Section 5123 Statue, I will pay a fee of $ _____. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

Patient/Guardian Signature _____ **Date**_____

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Southern Vascular Associates LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. Please refer to Southern Vascular Associates LLC Notice of Privacy Practice for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practice prior to signing this consent. Southern Vascular Associates LLC reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Southern Vascular Associates LLC Privacy Officer at 5000 Ambassador Caffery Pkwy Building 1, Suite 100, Lafayette, Louisiana 70508.

With my consent, Southern Vascular Associates LLC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out care, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Southern Vascular Associates, LLC may mail to my home or other designated location any items that assist in carrying our care, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

However, the practice is not required to agree to meet requested restrictions, if it does, it is bound by this agreement.

By signing this form, I am consenting to Southern Vascular Associates LLC use and disclosure of my PHI to carry out care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Southern Vascular Associates LLC may decline to provide treatment to me.

_____ _____

Signature of Patient/Legal Guardian **Date**

_____

Patient's Name Printed