VEIN CLINICS OF AMERICA

Authorization for Communication of Protected Health Information

Patient Name (print) Date of Birth Medical Record Number

I understand Vein Clinics of America personnel often need to communicate with patients, either directly or through a third party business associate acting on their behalf. This communication may involve information, or ask for feedback, about appointments, treatment, instructions, lab results, payment, or other items related to care at Vein Clinics of America, and may contain or reference protected health information. I also understand speaking personally with each patient is not always possible to communicate this information. By executing this authorization, I hereby authorize Vein Clinics of America personnel, or business associates acting on their behalf, to use all the contact information I have provided, including information on my Patient Information form, to contact me for the purposes described in this document.

I understand that texting is not a secure method of electronic communication, and there is a possibility that texts can be read by someone other than the intended recipient. If I have provided my cell phone number as a means of contacting me, I still wish to receive text reminders for upcoming appointments and other messages from Vein Clinics of America or business associates acting on its behalf.

By providing their name and contact information below, in addition to informal authorization I previously made, I authorize Vein Clinics of America to share information about my care or treatments at Vein Clinics of America (that may include Protected Health Information) with the following people:

A) Name _____ @ _____

B) Name _____ @ _____

I hereby release, discharge and agree to hold harmless Vein Clinics of America and all third parties acting on its behalf for the purposes described herein from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This authorization does not expire unless otherwise revoked in writing.

Signature of Patient or Patient/Guardian Date

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Relationship to Patient if Minor