



California Vascular & Vein Center
HIPAA Notice of Privacy Practices 3 of 3

Notice of Written Consent/Authorization
Verbal/Written Disclosure of Protected Health Information

I hereby give consent /authorization to California Vascular & Vein Center
To release either verbally/in-writing Personal Health Information (PHI) including all
other medical information with regard to my care and treatment to the following
individuals:

- 1. Name Relationship Restrictions
2. Name Relationship Restrictions
3. Name Relationship Restrictions
4. Name Relationship Restrictions

As the undersigned, I fully understand this document makes null/void any prior copies as
consent/authorization for disclosure of my protected health information (PHI).

Patient Name - PRINTED DATE

Patient Name - SIGNATURE

Witness - (Initials) CVVC Representative

This notice was published and became effective on or before April 14, 2003.
Rev (1) May 17, 2010

You may revoke this authorization, at any time, in writing, except to the extent that your
physician's practice has taken an action in reliance on the use or disclosure indicated in
the authorization.