CVC

MALLIK THATIPELLI, MD

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone Number: _____ Social Security#: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: CALIFORNIA VASCULAR & VEIN CENTER

Address: 2808 F Street, Suite A

City: Bakersfield State: CA Zip Code: 93301

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

NEITHER TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS WILL BE CONDITIONED ON PROVIDING OR REFUSING TO PROVIDE THIS AUTHORIZATION

THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY
THE UNDERSIGNED MAY CANCEL THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A WRITTEN REQUEST TO MEDICAL RECORDS

I UNDERSTAND THAT I MAY INSPECT OR COPY THE INFORMATION TO BE USED OR DISCLOSED

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.