Vein and Vascular Center of South Florida
David M. Feldbaum MD FACS
Horacio Schlaen MD FACS
Rodrigo B. Fonseca MD

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____authorize **Vein & Vascular Center of South Florida** to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medication information and billing information) to the following named persons.

Yo_____ autorizo **Vein & Vascular Center of South Florida** darle o discutir informacion relacionada con mi condicion medica (incluyendoinformacion relacionada con mi plan de tratamiento, resultados de laboratorios, medicamentos eh informacion de mi cuenta medica) a las siguientes personas:

1._____ 3._____

2._____ 4._____

Only persons listed above will be able to receive information related to your care. This office will not be able to disclose information to any other persons.

X_____ **date**_____

PATIENT SIGNATURE (firma de paciente)

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I_____, have reviewed/received a copy of Vein & Vascular Center of South Florida's notice of privacy practices.

RECIBO DE NOTIFICACION DE PRACTICAS PRIVADAS
FORMATO DE CONOCIMIENTO POR ESCRITO

Yo_____, eh revisado y recibido una copia de Vein & Vascular Center of South Florida notificado de practicas privadas

X_____ **date**_____

PATIENT SIGNATURE (firma de paciente)