Boston Vein Care

Medical Records Release Consent

I hereby authorize Boston Vein Care to RELEASE or OBTAIN my medical record information as specified below:

Patient Name:_____ Date of Birth:_____

☐ Boston Vein Care may **RELEASE** copies of my medical records to:

_____
Physician/ Institution Name

_____
Address

_____
City/State/Zip

_____
Phone/Fax Number

☐ Boston Vein Care may **OBTAIN** copies of my medical records from:

_____
Physician/ Institution Name

_____
Address

_____
City/State/Zip

_____
Phone/Fax Number

INFORMATION TO BE RELEASED: (Please check all that apply)

- ☐ Office /Consult Notes
- ☐ Radiology/Imaging Studies (CT, MRI, US)
- ☐ Medicine, Echocardiography, X-Ray, etc.)
- ☐ Lab Results
- ☐ Other:_____

MEDICAL RECORDS REQUESTED BY BOSTON VEIN CARE SHOULD BE SENT TO:
1 Courthouse Lane #9
Chelmsford, MA 01824
Phone: (855) 798-3467
Fax: (888)-561-3002

Information to be excluded from this release:_____
_____
(please list specific information to be excluded from release if applicable)

This information will be used for the following purposes: Treatment, Payment (e.g. insurance companies), and Routine Healthcare Operations.
This authorization is valid for one year from the date of this authorization or until _____.
(Insert date here)

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient