Boston Vein Care

Medical Records Release Consent

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

Date of Birth: Boston Vein Care may **RELEASE** copies of my Boston Vein Care may **OBTAIN** copies of medical records to: my medical records from: Physician/Institution Name Physician/Institution Name Address Address City/State/Zip City/State/Zip Phone/Fax Number Phone/Fax Number INFORMATION TO BE RELEASED: (Please check MEDICAL RECORDS REQUESTED BY all that apply) **BOSTON VEIN CARE SHOULD BE** ☐ Office /Consult Notes **SENT TO:** ☐ Radiology/Imaging Studies (CT, MRI, US) 1 Courthouse Lane #9 ☐ Medicine, Echocardiography, X-Ray, etc.) Chelmsford, MA 01824 ☐ Lab Results Phone: (855) 798-3467 Other:_____ 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