Vascular Health Center
Comprehensive Vascular Care

Tarek El-Shaarawy, M.D.
Syed M. Faisal Alam, M.D.

AUTHORIZATION OF RELEASE

Vascular Health Center values your confidentiality and follows all applicable laws regarding the release of patient information. We will not release any medical information to anyone without your authorization. Please list below any individuals you would allow our office personnel to speak to regarding your medical information. These eligible individuals would possibly have messages left with them regarding lab and diagnostic results, medication information, and referral appointments. They may live in your household, be a neighbor or friend, or be a family member. Please make sure to include the individual's relationship to you below. You will not need to list your Primary Care Physician or Referring Physician.

We cannot release any information (including appointment information) to anyone that is NOT listed on this form.

I, _____ , authorize Vascular Health Center to release information regarding my medical information to the following individuals:

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

By signing this form, I understand that this applies to all information in my medical record protected under the regulation 42 code of federal regulation, Part 2. I authorize medical treatment to be released as indicated above. I understand this release will be in effect until revoked in writing by myself. This form may be updated or revoked at any time.

_____ _____
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

_____ _____
WITNESS SIGNATURE **DATE**

3790 Capital Avenue S.W. • Battle Creek, MI 49015
Phone (269) 979-6310 • Fax (269) 979-8807