Artery and Vein Institute, LLC
Consent for Release of Information

Patient name _____
Date of birth_____
Address:_____

I do hereby authorize:

_____

_____

_____

To release my records to:

Artery and Vein Institute, LLC
2924 Swede Rd
East Norriton PA 19401

The purpose of this release is to provide ongoing medical care. However, I do not give permission for any other use or redisclosure of this information.

The information to be included is the following:

_entire chart _other diagnostic tests _ laboratory results _EKG/echo/stress

_ correspondences_ H&P/Discharge summaries _ radiology reports

By signing the following, I understand my record may contain:

*drug or alcohol information

*psychiatric/psychological information

*HIV related information

I understand that by law, I do not have to release this information and I do so voluntarily. I understand I may cancel this release, in writing, at any time unless the information has been sent. This authorization will expire twelve (12) months from the date listed below.

Patient/Parent/Guardian _____

Date _____

Witness_____

Please fax records to (484)370-8135