Demetrios Karamichos, MD
RPVI, RVT, DABVLM

REGION VEIN
Better Options. Healthier Legs.®

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____ Date of Birth: _____/_____/_____

Fax, mail or hand deliver completed form to the facility you want records transferred from.

I hereby request and authorize:

Name of Facility: _____ Phone: _____

Address: _____ Fax: _____

To furnish medical records to Region Vein, please release the following information:

❑ Initial Consultation ❑ Last Two Progress Notes ❑ Most Recent Ultrasound Reports/Maps For Each Leg

❑ Other _____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I UNDERSTAND THIS AUTHORIZATION IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN BASED UPON IT. I ALSO UNDERSTAND THIS AUTHORIZATION WILL EXPIRE IN ONE (1) YEAR FROM THE DATE SIGNED UNLESS I SPECIFY OTHERWISE.

Signature: _____
(Patient)

Signature: _____ / _____
(Parent/Guardian) *(Relationship)*

Signature: _____ / _____
(If Patient is unable to sign) *(Reason)*

Date: _____

Please mail or fax records to:

931 Ridge Road, Suite C, Munster, IN 46321 | **Fax:** 219.881.8776

219.595.3095 | 1.888.Leg.Vein **www.regionvein.com**