REGION VEIN
EXCEPTIONAL VEIN CARE

Demetrios J. Karamichos, MD
RPVI, RVT, DABVLM, FAAFP

HIPPA CONTACT LIST

If you would like additional people to assist in your care, please complete the following:

I, _____, give permission to **Region Vein** to release the
(PLEASE PRINT)
following information to the individuals listed:

1. _____

Name **Relationship** **Best Contact #**

❑ Medical History ❑ Treatment ❑ Appointment Times ❑ Billing Information

2. _____

Name **Relationship** **Best Contact #**

❑ Medical History ❑ Treatment ❑ Appointment Times ❑ Billing Information

3. _____

Name **Relationship** **Best Contact #**

❑ Medical History ❑ Treatment ❑ Appointment Times ❑ Billing Information

4. _____

Name **Relationship** **Best Contact #**

❑ Medical History ❑ Treatment ❑ Appointment Times ❑ Billing Information

I understand that I have the right to inspect and receive a copy of the information to be disclosed, and I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization.

Patient Signature: _____ Date: _____