Medical Records Release Request

Patient Name: ___________________________________ Date of Birth: ____________________

Phone: ____________________________other name(s) patient may have gone by:____________________________

☐ **RELEASE OF NORTHEAST WISCONSIN VEIN CLINIC RECORDS TO OUTSIDE FACILITY**

☐ **REPORTS** ☐ **FULL RECORD**

Office Visit / Procedure Dates:____

To Physician/Facility: ____

Mailing Address, City, State, Zip: ____

Fax: ____ Phone: ____

► I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.

► This Authorization shall be effective for two years or until I revoke it in writing.

______________________________________	____	__________________
Patient or Representative Signature	Printed Name	Date

*Must be parent, legal guardian and/or have written proof of Authorized Representative and a copy of this proof must be attached to this release/request.

Important:
This facsimile contains PRIVILEGED AND CONFIDENTIAL health/doctor/company information intended only for the use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone.

The Northeast Wisconsin Vein Center is closed as of 3/31/2024.

Please fax this request to 920-722-1928
OR mail to 333 N. Commercial Street, Suite 100
Neenah, WI 54956.

PATIENT COPY