LUMIERE COSMETIC VEIN CENTER, P.A.
Authorization to Release Medical Records

Return this form via fax to (855) 574-2200.

I, _____, hereby authorize Dr. _____ of _____ to release any and all information in my patient records including alcohol, drug abuse, psychiatric, and/or AIDS related records and/or HIV test.

_____/_____
Patient Name Date of Birth

1. This information is to be released only to the following person(s), institution(s):

   _____
   Name / Title of Person / Organization

   Records are to be mailed/emailed/picked up/faxed. (Circle which applies and provide necessary information: fax #, email address, mailing address, etc.)

   _____

2. Lists the records and dates you **do not** authorize to release or circle **all records** if you authorize your entire record and all dates to be released to the above.

   _____

I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I must present my written revocation to the President, Lumiere Cosmetic Vein Center, P.A. at 2546 Heydon Lane, Suite 2, Cape Coral FL, 33991. I understand any disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by federal privacy rules. The MD or facility may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization. This authorization and consent will remain in effect until revoked in writing.

Lumiere Cosmetic Vein Center, P.A. reserves the right to charge a fee for retrieval, copying, certification, and postage related to this request, not to exceed the rates published annually by the Florida Department of Community Health.

_____	_____	_____
Patient Signature / Minor Patient Signature	Printed Name	Date Signed
_____	_____	_____
Parent/Guardian Signature (if applicable)	Printed Name	Date Signed

REQUESTED RECORDS:
___ FULL CHART
___ H&Ps
___ MEDICATIONS/ALLERGIES
___ OFFICE VISITS (DATES:_____)
___ PROCEDURE NOTES (DATES:_____)
___ HOSPITAL RECORDS (DATES:_____)
___ OTHER: _____

Joseph Cipriano, D.O.
2546 Heydon Lane, Suite 2
Cape Coral, FL 33991