

Eastside Vascular L.L.P.

• Vascular, General and Thoracic Surgery • Non-Invasive Vascular Lab
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Mark P. Ombrellaro, M.D. Allen D. Rubin, M.D.

Authorization for Dr.Ombrellaro and Dr. Rubin to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that applies);

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition: _____
- Health care information in my medical record for the date (s): _____
- Other (e.g., X-rays, bills), specify date (s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Psychiatric disorders/mental health
- Pregnancy
- Sexually transmitted diseases
- Drug and/ or alcohol use

You may disclose this health care information to self _____ or to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Reason (s) for this authorization (check all that apply):

- At my request
- Check only if Dr. Ombrellaro and Dr. Rubin requests the authorization for marketing purposes
- Check only if Dr. Ombrellaro and Dr. Rubin will get paid or get something of value for providing health information for marketing purposes
- Other (specify) _____

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed)*

- In 90 days from the date signed
- When the following event occurs: _____ (no longer than 90 days from the date signed)
- On (date): _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

However I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third for a third party.

I may revoke this authorization in writing, If I did, it would not affect any actions already taken by Dr.

Ombrellaro and Dr. Rubin based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Dr. Ombrellaro and Dr. Rubin.
- Write a letter to Dr. Ombrellaro or Dr. Rubin.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date Time

Printed name

Relationship (parent, legal guardian, personal representative)