CORONADO
VEIN CENTER

Patient Registration
(PLEASE PRINT)

First Name: _____ Middle Initial: _____

Last Name: _____ Sex: M F

Social Security #: ___ - ___ - ___ Date of Birth: ___ / ___ / ___

Mailing Address: _____

_____

Email Address: _____

Phone Number: Home: _____ Mobile: _____

Work: _____

Marital Status:

☐ Single ☐ Married ☐ Legally Seperated ☐ Divorced ☐ Widowed

Employment Status:

☐ Retired ☐ Employed ☐ Full-time Student ☐ Part-time Student

Race/Ethnicity:

☐ White/Caucasian ☐ Black/African American ☐ American Indian

☐ Asian/Pacific Islander ☐ Hispanic

Preferred Language:

☐ English ☐ Spanish ☐ Other: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work/Cell Phone: _____

Address: _____

_____

2126 Eureka Way, 96001
910 Main Street, 96080
194 Cohasset Road, 95626
874 Plumas Street, Suite 100, 95991

Redding | 244.3278
Red Bluff | 527.2688
Chico | 343.7733
Yuba City | 790.7788

PERSONAL REPRESENTATIVE AUTHORIZATION
FOR MEDICAL RELEASE FORM

I, authorize The Coronado Vein Center and staff to speak to the following family members or my personal representative regarding:

☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurses and doctors notes and any other non-medical information in my file.

☐Only the following types of information:

_____

_____

_____

The above medical information shall only be released to the following persons:

Family Member/Personal Representatives Relationship

_____

_____

_____

I understand that I may terminate this Medical Authorization Form. I must notify The Coronado Vein Center in writing regarding termination and effective date.

This authorization shall remain valid until revoked in writing.

I know that I am entitled to receive a copy of this agreement.

Signature: _____ Date: _____

Print Name: _____

Authorization for the Release of Medical Information
Coronado Vein Center

Authorization for use/or disclosure of protected health information. *Patients: Please fill bottom portion only.*

I, hereby authorize_____
(Name of Disclosing Party)

_____
Address

_____ _____ _____
City State Zip

_____ _____
Phone Fax

To Disclose to the **Coronado Vein Center**

_____
Address

_____ California _____
City Zip

_____ _____
Phone Fax

Name of Patient_____DOB_____

Specify the records to be disclosed:

*Medical Information_____Date_____
*X-Ray Results_____Date_____
*Lab Results_____Date_____
*Progress Notes_____Date_____
*Consultation Report_____Date_____
*Other_____Date_____

----------*Above For Office Use Only*----------

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signed_____ Witness Signed_____

Name_____ Name_____

Date_____ Relationship to Patient_____