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 Separated ☐ Divorced ☐ Widowed

Employment Status: ☐ Retired ☐ Employed ☐ Student

Race: _____ Ethnicity: _____ ☐ Decline to Report

Preferred Language: _____

Emergency Contact

First & Last Name: _____ Relationship:_____

Primary Phone: _____ Secondary Phone: _____

Address: _____

_____

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_____

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: _____

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that the Coronado Vein Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

The Coronado Vein Center has a detailed document called the "***Notice of Privacy Practices***". It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing this agreement. If I ask, the Coronado Vein Center will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow the Coronado Vein Center to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except that the extent that the Coronado Vein Center has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Authorized Representative) **DATE**

_____ _____

RELATIONSHIP TO PATIENT if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices,* including and revisions of our "*Notice"* at any time by contacting Coronado Vein Center, Redding at 530-244-3278.