GulfCoast Vein & Laser Center

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____
(Patient Name – Please Print)

Date of Birth _____ **Last Four of S.S. #** _____

give Gulf Coast Vein & Laser Center authorization to release my medical records to:

_____
Name

_____
Address

_____
City, ST & Zip **Phone**

X_____ **X**_____
Patient Signature **Date**

Records Mailed _____ **Records Faxed** _____ **Records Given To Patient**_____

# of Pages _____ **Employee Initials** _____ **Date Completed**_____