HORMOZE A. GOUDARZI MD PA – SPOTLESS VEIN CARE

1721 NEW HANOVER MEDICAL PRK DR, WILMINGTON, NC 28403

PHONE:910 264 - 2803 FAX:910 726-3661

EMAIL:BEV8001K@GMAIL.COM

PATIENT NAME: .....

PATIENT ADDRESS: .....

PATIENT DOB: ..... PATIENT SSN: ..... CONTACT PHONE #: .....

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, urgent cares and/or clinics which are a part of my medical records.

PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes.

It also includes any information concerning cancer, cancer testing and cancer results. I agree that a fax or emailed copy of this release form shall be as valid as the original release. Please send copies of all request information as soon as possible to the address listed below:

☐ SEND ALL MY RECORDS

☐ SEND RECORDS FROM (DATE)_____TO (DATE)_____

☐ SEND MY RECORDS PERTAINING TO _____

Mailing address

_____

_____

City: _____ State: _____ Zip code. _____

Fax to: ……

I have read the consent and recognize the office policy allows **14** business days for records to be mailed/ faxed.

PATIENT SIGNATURE: …… DATED: ……