Hormoze A. Goudarzi, MD PA | Spotless Vein Care

Mailing Address: PO Box 16513, Wilmington, NC 28408
Phone – Main Line: (910) 264-2803 | Medical Records: (910) 899-0563
Fax: (910) 726-3661 | Email: contact@spotlessveincare.com
Website: https://www.spotlessveincare.com

AUTHORIZATION TO RELEASE INFORMATION FORM

Fill out all required fields on the form provided below. Ensure all information is accurate and legible.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), federal law pertaining to Early Childhood Intervention (34 C.F.R. part 300), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (N.C.G.S. 122C).

PATIENT INFORMATION

Name:

Address:

City: State: Zip Code:

Date of Birth:

Social Security Number (last four digits):

Contact Phone:

PERSONS/ORGANIZATIONS PROVIDING THE INFORMATION

Name: Hormoze A. Goudarzi, MD PA

PERSONS/ORGANIZATIONS RECEIVING THE INFORMATION

Name:

Mailing Address:

City: State: Zip Code:

SPECIFY DESCRIPTION OF INFORMATION *(Select all that apply.)*

☐ Send all my records

☐ Send my records from Date: to Date:

☐ Send my records pertaining to:

I understand that this authorization will expire on July 1, 2025 or one year from the date it is signed, whichever is earlier.	Initials:

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received.	Initials:
I understand that I am authorizing the release of substance abuse, AIDS, HIV, or other communicable diseases, if such information is present in my record.	Initials:
I agree that a fax or emailed copy of this release form shall be as valid as the original release.	Initials:

_____
Signature of Patient or Patient's Representative (Form MUST be completed before signing).

_____
Date

_____
Printed Name of Patient's Representative

_____
Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Submit Via Mail
Mail the signed form to the address below:

Hormoze A. Goudarzi, MD PA
PO Box 16513
Wilmington, NC 28408

Submit Via Fax
Fax the signed form to the following number:
(910) 726-3661

Submit Via Email
Scan or take a clear photo of the completed and signed form.
Attach the scanned/photo file to an email.
Send the email to: contact@spotlessveincare.com