Hancock Vein & Surgical Center

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www.hancockvein.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____Date of Birth: _____
Previous Name: _____SSN: _____

I request and authorize Dr. Susan Hancock to release healthcare information for patient named above to:

Doctor's Name: _____
Street Address: _____
City, State, Zip: _____
Telephone #: _____ Fax #: _____

This request and authorization applies to:
___Healthcare information related to the following treatment, condition, or dates:
_____
___All healthcare information
___Other:_____
_____

Patient Signature: _____Date: _____
Parent or Guardian Signature: _____ Date: _____