

THE VAIN CLINIC, LLC

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TO: _____

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

Re: Name of Patient _____

Social Security # _____ DOB: ___/___/___

I authorize the release of my medical records, specifically to include the following:

Complete Medical Records _____ Lab Reports _____ Consultations _____

Medications _____ Other _____

This medical record may contain information about drug abuse, substance abuse, mental health treatment and HIV/aids information. Separate consent must be given to release this information.

_____ I DO consent to having this information disclosed

_____ I DO NOT consent to having this information disclosed

The purpose of this request is for diagnosis and treatment.

These records are to be sent to the above address.

This authorization will expire 90 days from the date of signing.

I have the right to revoke this authorization at any time, in writing, except to the extent of information that has already been released.

I have reviewed this authorization. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

Date: ___/___/___

Signature of Patient or Personal Representative

Description of Personal Representative