



1510 South Central Avenue Suite 200 • Glendale, CA 91204
 1 888 SO CA VEINS (1.888.762.2834) (818) 500.9934 FAX (818) 500.9935
 www.varicoseveinsurgeons.com email: contact@varicoseveins.com

Consent to Release Verbal or Written Information

The State of California mandates that medical information may be shared only with the patient or the patient’s legal representative. In accordance with this law, every employee of **Varicose Vein Surgeons** is required to sign Confidentiality Statement on an annual basis, indicating they will keep the medical information of every patient in the strictest confidence.

Adhering to the confidentiality Policy is difficult when family members (spouse, children, and siblings) inquire about a patient’s medical care. The staff and/or physicians cannot release medical information without permission from the patient or the patient’s legal representative.

If you wish to give **permission** for staff and/or physicians to **verbally release general medical information to family members**, list the name(s) and relationship of those individuals in the space provided below.

“General Medical Information” excludes the discussion of Psychiatric Services; Drug and Alcohol Counseling; Sexually Transmitted Disease; HIV Testing; Pregnancy or Termination of Pregnancy.

If you do not wish to give permission for general medical information to be released verbally to family members, check here and sign below.

Name	Date of Birth	Relationship

I authorize that the above individual(s) may have access to information regarding my general medical condition. I will notify Varicose Vein Surgeons if I wish to ass or delete individuals who may have access to my medical information.

 Patient’s Name (PRINT)

 Date

 Patient’s Signature

 Witnessed By