



**THE VEIN & VASCULAR  
INSTITUTE OF TAMPA BAY**  
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**PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**NOTICE:** In accordance with **HIPPA** Privacy Rule, 45 CFR 164. 502 (b) (2) (ii), this Authorization is not subject to the **HIPPA** Minimum Necessary standard.

I, the undersigned, as the patient or in my capacity as personal representative of the patient, \_\_\_\_\_, understand the information obtained by this Authorization will be used by Thomas M. Kerr, MD/Marlene D. Valentin, M.D. for the purpose of verifying, evaluating, negotiating, and other pertinent legal uses, in connection with my claim for personal injury.

Although the information released pursuant to this Authorization may no longer be protected by federal privacy regulations, any information obtained will not be released by Thomas M. Kerr, MD/Marlene D. Valentin, M.D. to any person or organization in any individually identifiable for **EXCEPT** to its other affiliates or other persons or organizations performing business or legal services in connection with my claim, including but not limited to subrogation and medical review, or as may be otherwise permitted or required by law, or as further authorized by me.

I authorize the following persons and organization (the Provider) to provide information (as defined below) to Thomas M. Kerr, MD/Marlene D. Valentin, M.D. and/or its representatives, employees or investigators, from (a) any licensed physician, surgeon, or dentist ; (b) any psychiatrist or psychologist ; (c) any other medical practitioner or nurse ; (d) any hospital, clinic, health care facility or rehabilitation/ convalescent/ custodial facility ; (e) ambulance service ; or (f) any insurance company.

For purposes of this Authorization, "Information" means all written records or knowledge concerning the patient's health, any injuries, medical history, mental and physical conditions, before and after the date of this Authorization, regardless of the time or occurrence. The term "record" includes, but is not limited to, written or graphic documentation, including notes, billing records or statements, sound recordings, computer records of health care services, and diagnostic documentation such as x-ray and MRI films/ reports, lab test results, and any other test results. In addition to medical records developed by the Provider described above, this Authorization also includes any medical records received by the Provider from other providers.

This Authorization shall be in force and effect until revoked, at which time this Authorization to disclose information will expire.

I understand that I may receive a copy of this Authorization, and I have the right to revoke this Authorization, in writing, at any time. I may request a copy or revoke the Authorization by sending such written request, either my mail or e-mail, to Thomas M. Kerr, MD/Marlene D. Valentin, M.D. 2809 West Waters Ave, Tampa, Florida 33614. I understand that a revocation is not effective until (i) received by Thomas M. Kerr, MD/Marlene D. Valentin, M.D., and (ii) to the extent that Thomas M. Kerr, MD/Marlene D. Valentin, M.D. has relied on the use or disclosure of the information.

I agree that (1) this Authorization overrides any existing agreement to restrict information pursuant to 45 CFR 164. 50 (b) (2) (ii), (2) a copy of this Authorization is as valid as an original, and (3) I have read and understand this Authorization.

**THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES:**

Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_