

DELAWARE VALLEY VEIN CENTERS

PATIENT AUTHORIZATION

I hereby give permission for **DELAWARE VALLEY VEIN CENTERS**
to disclose information regarding my treatment to:

SPOUSE

SON/DAUGHTER

OTHER RELATIVE _____

OTHER HEALTHCARE PROVIDERS TAKING PART IN YOUR MEDICAL TREATMENT

ALL OF THE ABOVE

OTHER _____

PERMISSION TO REQUEST A COPY OF MY MEDICAL RECORDS FROM:
ASSOCIATED SURGEONS P.C.

PATIENT NAME: _____

DOB: _____

SIGNATURE: _____

DATE: _____