Metro Vein *Centers* —

PATIENT REFERRAL FORM

Please fax completed form to (248) 479-0332

You can also refer by phone (866) 366-7142

PATIENT INFORMATION

Name: _____ Phone #: _____

REFERRING PROVIDER INFORMATION

Provider Name:_____

Name of Practice: _____

Office Address: _____

Phone #: _____Fax #:_____

Confidentiality Notice: Confidential Health Information Enclosed

Protected Health Information (PHI) is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is strictly prohibited. If you have received this in error, please notify the sender immediately to arrange for return or destruction of these documents.