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AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____

Date of Birth: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ HISTORY & PHYSICAL REPORT
☐ X-RAY REPORT
☐ ECG REPORT
☐ LAB REPORT
☐ PATHOLOGY REPORT
☐ MEDICATION RECORD
☐ OPERATIVE RECORD
☐ NURSE'S NOTES
☐ PROGRESS NOTES
☐ DISCHARGE SUMMARY
☐ CONSULTATION(S)
☐ PSYCHIATRIC CONSULTATION(S)
☐ ENTIRE MEDICAL REPORT
☐ DOCTOR'S ORDERS

Proposed new use of the above information without additional written consent of the patient to whom it pertains is prohibited.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Signature of Witness: _____

MEDICAL RECORDS: To obtain copies of your medical records you must sign this Authorization to Release Information form. There is also a small fee of $10.00 plus $0.50 per page. These fees, set forth by Virginia State law, must be paid in full before your request will be processed. Please allow 5-7 business days for processing.