



Virginia Cardiovascular Specialists

Permission to Release Medical Information

Date _____ Chart _____

Patient Name _____
(Last) (First) (Middle)

Address _____
(City) (State) (Zip)

Date of Birth _____ SS# _____

I hereby authorize the release of information concerning my medical history and/or treatment to/from the persons listed below:

Entire Medical Record To From Dr. _____
 Partial Medical Record VIRGINIA CARDIOVASCULAR SPECIALISTS

Entire Medical Record To From Dr. _____
 Partial Medical Record

Verbal Information To From _____

To From _____

To From _____

To From _____

Signature _____ Witness _____

For Office Use Only

_____ Date Requested _____ Date Sent _____ Initials _____

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