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
____
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❑ Entire Medical Record ❑ To ❑ From Dr. ______________________
❑ Partial Medical Record
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❑ Verbal Information ❑ To ❑ From ______________________
❑ To ❑ From ______________________
❑ To ❑ From ______________________
❑ To ❑ From ______________________

______________________ ______________________
Signature Witness

NOTE: There will be a charge for copies of records for personal, legal or insurance purposes. HealthPort has been contracted to provide this service and will invoice you directly.

For Office Use Only

______________________ ______________________ ______________________
Date Requested Date Sent Initials

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