Virginia Cardiovascular Specialists

Permission to Release Medical Information

Date ______________________________ Chart ________________________

Patient Name ____
(Last) (First) (Middle)

Address ____
(Street) (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. Ciox has been contracted to provide this service and will invoice you directly.

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For Office Use Only

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Date Requested Date Sent Initials

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