Winchester Cardiology and Vascular Medicine P.C.

1870 Amherst Street, Suites 100 & 200
Winchester, VA 22601
Phone: (540) 662-0306 Fax: (855) 264-2066

Authorization to Release Medical Information

Please release medical information for:

_____ _____
Print Patient's Name Birth Date

_____ _____
Street Address Home phone

_____ _____
City, State, Zip Code Alternative phone

_____ _____
Parent/Guardian if Patient is younger than 18 yrs. Chart number

I, _____, do hereby authorize _____
Name/Agency/Facility/Person

at _____
Street address-if different than patient's. City, state, zip code

_____/_____
Telephone/Fax

Information to Release

_____ Please release the following <u>at no charge</u>: last 2 office visits, last lab, last EKG, for continuing care
_____ Please release the following listed below <u>at my expense</u> according to Virginia State Rates:
Service Dates Requested From _____ to _____
_____ Office Notes _____Surgical or Procedures _____ Medications
_____ Cardiac Tests/ECG/EKG _____ Pathology (Lab) Reports _____ Entire Chart
_____ Radiology (x-ray) Reports

_____I do _____ I do NOT authorize release of information related to AIDS (acquired Immunodeficiency Syndrome), HIV (Human Immunodeficiency Virus) Infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

_____Personal use, email delivery. Complete Electronic Record Delivery Request.

To send records to: _____/_____
Name/Agency/Facility/Person Telephone/Fax

_____, _____
Street address City, State, Zip Code

Purpose of Disclosure: ____ Referral ____ Insurance ____ Workers Comp ____ Changing Practices ____ Legal Investigation _____ Disability Determination ____ Personal ____ Removing/Relocating ____ Continued Care
_____Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

X_____ Date _____
Signature of Patient or guardian or Personal Representative of patient's estate (executor information must be provided).

Note: Virginia Law permits a charge for personal copy/transfer of your records. Pre-payment may be required of some non-medical claim insurance company requests. Virginia Rates are pages 1-50 at $0.50 per page(s) 51+ at $0.25 per page.