VALLEY
PAIN CONSULTANTS
In Partnership with ValleyHealth

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AUTHORIZATION for RELEASE OF MEDICAL INFORMATION

Patient information

Last Name, First Name_____ Date of Birth_____

Address _____ SSN _____

_____ Phone 1 _____

City, State, Zip _____ Phone 2 _____

I authorize ○ Valley Pain Consultants ○ _____ to release medical records to:

Name of Facility/Person_____ Relationship to Patient_____

Address _____ Phone _____

City, State, Zip _____ Fax _____

Information to be Disclosed

☐ All Records ☐ Operative Reports ☐ History & Physical

☐ Radiology Reports ☐ Office Notes ☐ Other/Date Range_____

Purpose of Disclosure

☐ Continuing Care ☐ Personal ☐ Change of Doctor ☐ Other_____

☐ Legal Investigation ☐ Disability Determination ☐ Workers Comp

I hereby authorize disclosure of the health information for the above named patient. This information may include psychiatric, substance abuse, and HIV/AIDS information. 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 may receive a copy of this authorization for my records. Unless otherwise specified, this authorization expires 2 years from the date signed.

_____ _____

Patient/Guardian Signature Date

_____ _____

Printed Name Relationship to Patient

NOTE: Virginia Law permits a charge for personal copy / transfer of your records. Healthport has been contracted to provide this service and will invoice you directly. Virginia Rates are pages 1-50 at $0.39 per page, with pages 51+ at $0.15 per page plus actual postage & handling. PRE-PAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS.