



190 Campus Boulevard, Suite #201
Winchester, VA 22601
Phone: 540 662-0306
Fax: 540 504-0003

Authorization to Release Medical Information

Please release medical information for:

Print Patient's Name
Street Address
City, State, zip code
Parent/Guardian if Patient is younger than 18 yrs.

Birth Date
Home phone
Alternative phone
Chart number

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

Street address City, state, zip code
Telephone/Fax

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

Street address City, state, zip code

Information to Release

_____ Please release the following at no charge: last 2 office visits, last lab, last EKG, for continuing care
_____ Please release the following listed below at my expense according to Virginia State Rates.

Service Dates Requested From _____ to _____
Including: _____ Hospital History & Physical _____ Hospital Discharge Summary _____ Operative Notes _____ Progress Notes
_____ Radiology (x-ray) Reports _____ Pathology (Lab) Reports _____ Cardiac Tests/ECG/EKG _____ Medications
_____ Immunization _____ Entire Chart _____ All of the Last 2 Years

_____ 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.

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. Healthport is contracted to provide this service for Winchester Cardiology & Vascular Medicine, PC and may invoice you directly. Pre-payment may be required of some non-medical claim insurance company requests. Virginia Rates are pgs 1-50 at \$0.50 per pg, pgs 51+ at \$0.25 per pg.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE _____ LAB _____ EKG _____
DS _____ EKG _____ IMMUNE _____
OP _____ XRAY _____ ROI SPECIALIST _____
HP _____ PATH _____ OTHER _____ DATE _____