VIRGINIA CARDIOVASCULAR CONSULTANTS
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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____Date of Birth:_____
Phone Number: _____

The information you may release subject to this signed release form is as follows:

_____ Complete Chart
_____ Physician Progress Note
_____ Laboratory Results
_____ Testing done at VCC (please specify) _____
_____ Other (please specify)

*Complete chart request include ONLY records/test results completed at Virginia Cardiovascular Consultants offices.

The purpose for the disclosure of the information is:
Continue Care _____ Personal Use _____ Other_____

Release my protected health information to__/from__ the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____
Address: _____
City, State: Zip Code: _____
Phone: _____
Fax: _____

How to send records:
Fax_____ Pickup_____

I understand that I may revoke this consent to release information at any time, except where actions have already been taken. I do not revoke it earlier, this authorization will expire in 6 months.

Patient Signature_____ **Date**_____