



2001 Crystal Springs Ave, Suite 300 Roanoke, VA 24014 Phone 540-342-7941 Fax 540-345-8423

CONSENT TO RELEASE MEDICAL RECORDS
(Please Print)

Patient Name: _____

Date of Birth: _____ Social Security: _____

Address: _____

Information to be released from:

Name/Facility _____

Address: _____

Purpose for Release: _____ Continuity of Care _____ Legal Representation _____ Relocation _____ Other

Covering Treatment Dates: From _____ To _____

Information to be released: _____ Cardiac Cath & Intervention Reports

_____ Office Notes _____ Testing Reports _____ Lab Reports

_____ Financial Records _____ Discharge Summary _____ All Records excluding
Financial

Other: _____

Release Records To: _____

Phone: _____ **Fax:** _____

Patient Pick-Up Mail Fax

I understand that information to be released may include information regarding drug and alcohol use, psychological or psychiatric impairments, sexually transmitted diseases, HIV and/or AIDS or physical conditions. If information pertaining to drug or alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal Confidentiality Regulations (45 CFR Part 2). Federal regulations prohibit you from making any further disclosure of this information unless is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Regulations restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without any further written consent unless provided for by state and federal law. A copy may be accepted by the health care facility in lieu of the original.

I understand I may revoke this authorization at any time, but my revocation is not in effect until delivered in writing to the agency holding my records, except in the event the action has already been taken place. If not previously revoked this consent will expire one year from the date of requesting party's signature.

Signature of Patient/POA Date Signature of Witness Date

Office Use Only: _____
Released By & Date Notes