Authorization to Release Medical Records

Patient Name: _____________________ Chart/ID Number: _________

This authorizes **Virginia Cardiovasular Associates, PC** to provide a copy, summary, or narrative of my medical records as indicated by the checkmark(s) below, or otherwise release confidential information.

- o Complete Records
- o Records of care from the following dates: ______________ to ______________
- o Records concerning the following conditions: ___________________________
- o Other, please specify: ____
- o Confer with person(s) listed below orally about my medical information:

The reasons or purposes for this release of information are as follows:

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HIV/AIDS (If Applicable) I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _______ **Date:** _______

Release to the following person(s):

Name: ____

Address: ____

City: __________________________________ **State:** ________________ **ZIP:** ___________

Expiration Date: __________ **or Expiration Event as detailed below:**

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- I understand that **Virginia Cardiovasular Associates, PC** will provide this information within 15 days from receipt of request and that a fee fro preparing and furnishing this information may be charged according to rulings set forth by the Virginia Statutory Code.
- I understand that I may revoke this authorization in writing at any time by notifying **Virginia Cardiovasular Associates, PC** in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.

Patient Signature: _______________________ Date: ________________