VIRGINIA VASCULAR CENTER
384 Hospital Drive
Warrenton, VA 20186
Phone 703-396-7669 Fax 703-396-7987
Authorization for Release of Medical Information

_____ _____
Patient's Full Name Birth Date (Mo/Day/Yr)

_____ _____
Street Address Phone (Home or Cell)

_____ _____
City, State, Zip Code Phone (Work)

Fees are waived when copies are requested by patients to send to other health care providers for continuing care or for personal use. All other requestors are charges as state and federal laws allow. **Photo ID is required.**

I, _____, hereby authorize **Virginia Vascular Center** to release:
(Patient, Legal Guardian)

COPIES OF PAPER MEDICAL RECORDS:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, consults and records received from other health care providers.

☐ Other as listed::

_____

I understand that I am giving my permission to release information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease, unless indicated in the following instructions as listed:

INFORMATION RELEASE TO:

_____
NAME (Physician, Hospital, Etc.)

_____
Street Address

_____
City, State, Zip

Purpose of Disclosure (circle one): Continuing Care, Personal, Insurance (fee), Attorney (fee), Workers Comp

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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 disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal regulations. I understand that the Virginia Vascular Center may not condition its providing of health care on whether copies to individuals or organizations are released as I request.

_____ _____
Signature of Patient or Legal Representative of Patient Date

If I am not the patient and am signing as the patient's legal (authorized) representative, I attest that the patient lacks capacity to make the decision to release the medical records as specified above.

_____ _____
Signature of Patient's Authorized Representative Date