Winchester Cardiology and Vascular Medicine P.C.

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

_____ Birth Date

_____ Street Address

_____ Home phone

_____ City, State, zip code

_____ Alternative phone

_____ Parent/Guardian if Patient is younger than 18 yrs.

_____ Chart number

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

at _____
Street address-if different than patient's. City, state, zip code

_____/_____
Telephone/Fax

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 _____

_____ Office Notes _____Surgical or Procedures _____ Medications
_____ Cardiac Tests/ECG/EKG _____ Pathology (Lab) Reports _____ Entire Chart
_____ Radiology (x-ray) Reports

_____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.

_____Personal use, email delivery. Complete Electronic Record Delivery Request.

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

_____, _____
Street address City, state, zip code

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 _____ OTHER _____
HP _____ PATH _____ _____

_____
ROI SPECIALIST

_____
DATE