1600 N. Coalter Street, Suite 19
Staunton, VA 24401
Phone: 540-885-4500
Fax: 540-885-4600

RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

DATE OF BIRTH: _____

LAST 4 DIGITS OF SOCIAL SECURITY: _____

The information covered by this release includes:

☐ **All information** including patient history, examinations, diagnoses, and treatments

☐ **Only the information specified below** (i.e. specific dates of service or type of service)

I hereby authorize the release of medical records for myself or my minor child to be transferred:

TO: _____ **FROM:** _____

_____ _____

_____ _____

_____ _____

_____ _____

Signature of Patient/Guardian Date