1600 N. Coalter Street, Suite 19
Staunton, VA 24401

Phone: 540-885-4500
Fax: 540-885-4600

30 Greenhouse Road
Lexington, VA 24450

*PATIENT NAME*_____
LAST *FIRST* *MI* *PREFIX/SUFFIX*

OR FORMERLY KNOWN AS: _____

*DATE OF BIRTH*____/_____/_____

The information you may release subject to this signed release form is as follows:

- ☐ *COMPLETE RECORDS*
- ☐ *PATHOLOGY*
- ☐ *LABS*
- ☐ *OTHER:* _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below:

TO:	*FROM:*
ADDRESS	*ADDRESS*
PHONE	*PHONE*
FAX	*FAX*

I hereby authorize the release of medical records for myself or my minor child to be transferred:
*Patient signature*_____ *DATE* _____

Printed name and relationship _____