



The Cardiovascular Group

CENTRA Stroobants Heart Center

2410 Atherholt Road
Lynchburg, VA 24501
(434) 544-2331 or (434) 200-5252

Authorization to Release Medical Records

Patient name: _____
Date of birth: _____ Chart number: _____

This authorizes The Cardiovascular Group of Central Virginia to provide a copy, summary, or narrative of my medical records as indicated by the checkmark(s) below, or otherwise release confidential information.

- Complete record
 Records of care from the following dates: _____
 Records concerning the following conditions: _____
 Other, please specify: _____
 Confer with the following person(s) orally about my medical information: _____

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

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: _____
Street: _____
City: _____ State: _____ Zip code: _____

Expiration date: _____ or expiration event as detailed below: _____

- I understand that The Cardiovascular Group of Central Virginia will provide this information within 15 days from receipt of request and that a fee for 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. 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-disclosures by the recipient and no longer protected by federal or state law.

Patient signature: _____ Date: _____