



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: _____

I hereby authorize and request you to release to:

Dr. _____ of The Cardiovascular Group of Central Virginia

2410 Atherholt Road

P.O. Box 11709

Lynchburg, VA 24506

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: _____

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

- 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: _____