Vascular Surgery Associates
7900 Shrader Rd
Henrico, VA 23294
Phone: (804) 288-1953
Fax: (804) 282-1046

MEDICAL RECORD RELEASE AUTHORIZATION

Patient Name_____ Maiden Name _____ SS#_____

Date of Birth_____ Home Phone_____ Cell / Work_____

Address _____ _____ City/State/Zip _____

Email address _____

A) I hereby authorize records FROM:

Name: _____

Address:_____

City/State/Zip:_____

Phone/Fax#: _____

B) To be released TO:

Name:_____

Address:_____

City/State/Zip:_____

Phone/Fax#:_____

C) This request is being made for the following purpose(s): _____

Date Range _____to_____

Physician office notes ___ Cardiology/EKG Reports___ Lab/Path/Radiology Reports___ Operative/Procedure Notes ___ Other ____

I understand that authorizing the disclosure of the health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) , or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ ****Subject to fees**

Date Signature of Patient/Parent/Guardian or Authorized Representative

This authorization will expire one year from the above date unless I specify an expiration date.

Please read fee information: Vascular Surgery Associates, PC reserve the right to charge the fee schedule as set by the State of Virginia. A $10.00 handling fee, $0.50 cents per page up to 50 pages and $0.25 cents per page for all other pages and postage may be invoiced to you with necessary directions to receive your records. By signing this authorization, you are agreeing to pay Virginia Surgical Associates, PC for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.