CENTRA
MEDICAL GROUP

Stroobants Cardiovascular Center

2410 Atherholt Road
Lynchburg, VA 24501
Phone (434) 200.5252

Authorization to Release Medical Records

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

I hereby authorize and request you to release to:
Dr. _____ of The Cardiovascular Group
2410 Atherholt Road
Lynchburg, VA 24501

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: _____