CENTRAL VA SLEEP CENTER
912 LAFAYETTE BLVD.
FREDERICKSBURG, VA 22401
540-656-2811
FAX 540-479-6961

Authorization for Release of Medical Records

Patient Information:

_____

_____

_____

_____

Date of Birth: _____

Social Security #: _____

Request Release From:

_____

_____

_____

_____

_____

_____

I hereby authorize you to release to _____ a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

_____ _____

Patient or Guarantor Signature Date

Please include the FOLLOWING ITEMS:

- ❑ Admission notes
- ❑ Discharge summary
- ❑ Operative reports
- ❑ EKG's
- ❑ X-ray reports
- ❑ Progress notes
- ❑ Pathology reports
- ❑ Consultation notes
- ❑ Laboratory tests
- ❑ Stress tests
- ❑ Other_____

Remarks: _____

This authorization will expire on _____