



VIRGINIA HEART

Excellence in Cardiovascular Care

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Records Request for Release of Protected Health Information

I hereby authorize Virginia Heart, to release my protected health information to:

Please release the following information:

All information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

The following test(s)/information only: _____

The purpose or need for this disclosure:

- | | |
|--|---|
| <input type="checkbox"/> Physician or health care facility | <input type="checkbox"/> Personal use |
| <input type="checkbox"/> Consult (2 nd opinion) | <input type="checkbox"/> Legal purposes |
| <input type="checkbox"/> Seeking a new physician | <input type="checkbox"/> Insurance purposes |
| <input type="checkbox"/> Physician availability | <input type="checkbox"/> Dissatisfaction |
| <input type="checkbox"/> Relocation | |
| <input type="checkbox"/> Other: _____ | |

I understand that Virginia Heart is not responsible for any subsequent disclosure of protected health information as a result of providing this information to the above-mentioned parties. I further understand that I am not required to disclose to Virginia Heart the reason for this request and that I may subsequently revoke this request, if necessary.

Virginia Heart requires that all requests be made in writing.

Signature

Date

Print Name

Date of Birth

Release expires one year from original date

Virginia Heart Use Only... Records Released by: _____