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:

❑ Physician or health care facility
❑ Consult (2nd opinion)
❑ Seeking a new physician
❑ Physician availability
❑ Relocation
❑ Other:_____

❑ Personal use
❑ Legal purposes
❑ Insurance purposes
❑ Dissatisfaction

_____

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:_____