



Records Request for Release of Protected Health Information

Patient Name Medical Record Number
Patient Date of Birth Contact Phone Number
Contact Email

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

Physician Other

Phone Number

Fax Number

Email

Name of Person or Entity to Receive Information

Street Address City State Zip Code

Information to be Released/Disclosed:

Entire Medical Records Medical records from to

The following test(s)/information only:

Purpose:

- Personal Use
Physician / Health Care Facility
Consult (2nd opinion)
Legal Purposes
Insurance Purposes
Relocation
Other:

Records Disposition (please choose one):

- Mail to address above Fax to fax number above Release to MyChart
I will pick up the records at the following Virginia Heart office location:
Alexandria Office Arlington Office
Fair Oaks Office Fairfax Office
Fairfax Office (Heart Rhythm Center) Fairfax Office (Sleep Center)
Lansdowne Office Loudoun Office
Purcellville Office Reston Office
Stone Springs Office Vienna Office

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.

Signature of Patient or Authorized Representative

Date

Print Name of Patient or Authorized Representative

Relationship to Patient

Release expires one year from original date

VIRGINIA HEART USE ONLY:

Records Released By: