# Records Request for Release of Protected Health Information

VIRGINIA HEART
Excellence in Cardiovascular Care
2901 Telestar Court, Suite 300, Falls Church, VA 22042
Phone Number: (703) 766-5873 • Fax Number: (703) 591-1503

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 <u>one</u>):**

☐ Please mail to address above
☐ Please fax to fax number above
☐ Please email to email address above
☐ I will pick up the records at the following Virginia Heart office location:

☐ Alexandria Office ☐ Arlington Office ☐ Fair Oaks Office
☐ Fairfax Office ☐ Loudoun Office ☐ Purcellville Office
☐ Reston Office ☐ Stone Springs Office ☐ Vienna Office
☐ Fairfax Office (Sleep Center) ☐ Fairfax Office (Heart Rhythm Center)

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: _____