CARDIOVASCULAR
ASSOCIATES, LTD.

PERMISSION TO RELEASE MEDICAL INFORMATION

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Date of Birth _____ Social Security # _____

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION CONCERNING MY MEDICAL HISTORY AND/OR TREATMENT TO/FROM THE PERSONS LISTED BELOW:

❒ Entire Medical Record ❒ Partial Medical Record ❒ To ❒ From Dr. _____

CARDIOVASCULAR ASSOCIATES, LTD.
MEDICAL RECORDS DEPARTMENT

❒ 1708 Old Donation Parkway
Virginia Beach, Virginia 23454

❒ 612 Kingsborough Square, Suite 100
Chesapeake, Virginia 23320

❒ 2075 Glenn Mitchell Drive, Suite 300
Virginia Beach, Virginia 23456

❒ Entire Medical Record ❒ Partial Medical Record ❒ To ❒ From Dr. _____

_____

_____

_____

_____

❒ Verbal Information ❒ To ❒ From _____

❒ To ❒ From _____

Signature _____ Relationship to Patient _____ Date _____

FOR OFFICE USE ONLY

Date Requested _____ Date Sent _____ By (name) _____ Verified By (name) _____

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