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. ____________________________

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  Virginia Beach, Virginia 23456

- Verbal Information

Dr. ____________________________

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  Chesapeake, Virginia 23320

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  Virginia Beach, Virginia 23456

Signature ____________________________
Relationship to Patient ____________________________ Date _________________

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