



CARDIOVASCULAR ASSOCIATES, LTD.

Tax # 54-1325391

PERMISSION TO RELEASE MEDICAL INFORMATION

Patient's Name _____
Last First Middle

Address _____
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

Cardiovascular Associates, Ltd.
Medical Records Department
110 Wimbledon Square, Suite D
Chesapeake, Virginia 23320

Entire Medical Record Partial Medical Record To From Dr. _____

Verbal Information To From

To From

Signature _____ Relationship to Patient _____ Date _____

F O R O F F I C E U S E O N L Y

Date Requested _____ Date Sent _____ Initials _____