

NEUROLOGY CENTER OF VIRGINIA, LLC

RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

Patient: _____
Last Name First Name M.I. Social Security Number Birth Date (MM/DD/YYYY)

Address: _____
Street City State Zip

I (or parent/guardian), _____, do hereby authorize
to release the following information from my medical records to:

Person or Agency to which disclosure is to be made or obtained:

Name: _____

Address: _____
Street City State Zip

Office/clinic Visit Date _____ Operative Report Date _____
 History & Physical Date _____ Laboratory Report Radiology Reports
 Pathology Report EKG/EEG Report Other:(specify) _____

*As the person signing this authorization, I understand that I am giving my permission to _____
for disclosure of confidential health records to include, if applicable, references to PSYCHIATRIC,
DRUG/ALCOHOL, HIV, or Hepatitis B or C viruses, testing/treatment, and /or other information contained in the
medical records, unless indicated in the following "Special Instructions."*

Special Instructions: _____

Purpose of Disclosure:

Physician Insurance Legal At the Request of Patient
 Disability Determination Personal Workers' Compensation
 Others (please specify): _____

I also understand that I have the right to revoke this authorization, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. **This authorization will expire 12 months from the date of the signature unless otherwise indicated.** A copy of the authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records, and a copy of any revocation will be included in my original records. I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and no longer be protected by law. I understand that my treatment will not be conditioned on whether or not I sign the authorization, except under specific situations as permitted by law. **A fee may be required in processing this request as permitted by Virginia law.**

Signature of Individual/Guardian/Personal Representative of Patient's Estate

Relationship to Patient

Date

Witness

Date

Expiration Date