Directions:

Please fill out, sign and return to one of our offices or the doctors office you are switching from. It can be returned through fax, mail, or in person.

VCC – Main Office | One Colonial Place | 10571 Telegraph Road, Suite 110 | Glen Allen, VA 23059 | 804.266.9616 | fax 804.261.4935
West End Office | John Rolfe Commons | 2304 John Rolfe Pkwy | Henrico, VA 23233 | 804.741.4404 | fax 804.750.1675
East End Office | Laburnum Sq. Office Park | 4786 Finlay Street | Richmond, VA 23231 | 804.226.4100 | fax 804.222.9508

Medical Records Release

Please complete the following information:
Patient(s) Name: ____
Patient(s) DOB: ____
Patient(s) Phone number: ____

I, ______________________, the parent or guardian authorize the records of my child(ren), to disclose/release the following information:
___All Records
___Laboratory/Pathology Records
___X-ray/Radiology Records
___Billing Records

Please send the records listed above:

___TO ___ FROM	___ TO ___ FROM
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

The information may be used/disclosed for each of the following purposes:
__ For my healthcare
__ For employment purposes
__ For payment/insurance
__ Other: ____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

______________________________________	____________________
Signature of Patient or Patient's Representative	Date
______________________________________	______________________________________
Printed name of patient representative	Representative's authority to sign for patient

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