OLD DOMINION MEDICAL CENTER

6715 Whittier Avenue, Mclean VA. 22101

TEL: 703-356-5700 FAX: 703-448-8211

Allen B. Horne, MD Fredrick W. Hubach, MD Patricia Leighton, NP

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

First Name:	Last Name:	Chart#: Social Security #:

Street Address:	City:	State:	Zip Code:

Phone #:	Date of Birth: (MDDYYYY)	Email:

I, _____, do hereby request and

authorize _____ to release the following healthcare information on the

patient named above...

- ☐ ALL RECORDS
- ☐ RECORDS FROM _____ THROUGH _____
- ☐ OFFICE NOTES
- ☐ IMMUNIZATION RECORDS
- ☐ LABORATORY REPORTS
- ☐ HISTORY & PHYSICAL
- ☐ OPERATIVE REPORTS
- ☐ RADIOLOGY REPORTS
- ☐ STD results, HIV/AIDS testing, whether negative or positive
- ☐ Records regarding drug, alcohol, or mental health treatment

TO:

Name:	Address:

City:	State:	Zip:	Telephone #:	Fax #:	Reason for disclosure:

_____ _____

SIGNATURE OF INDIVIDUAL/GUARDIAN/PERSONAL REPRESENTATIVE OF PATIENT'S ESTATE DATE

NOTE: PURSUANT TO VIRGINIA LAW (VA CODE 8.01-413), THERE WILL BE A $10.00 HANDLING FEE. THIS REQUEST IS GOOD FOR 6 (SIX) MONTHS FROM DATE OF SIGNATURE

PLEASE ALLOW FIVE (5) BUSINESS DAYS FOR PROCESSING _____

PLEASE INITIAL