Virginia Pediatric
Ophthalmology Specialists

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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____/_____/_____

Previous Name: _____ Social Security #: _____-_____-_____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED:

FROM _____ TO_____

_____ _____

_____ _____

This request and authorization applies to:

◯ Healthcare information relating to the following treatment, condition, or dates

_____

◯ All healthcare information ◯ Other

_____

I authorize VPOS to release/receive the confidential healthcare records of the above listed patient. I understand that I may restrict the discourse at any time, it is understood that these records can include any and /or all records relating to medical and/ or mental health conditions, drugs/alcohol diagnosis and treatment, HIV related treatment and diagnosis, I understand that this information will be used by my physician in the treatment of my medical condition.

◯ YES ◯ NO

PARTY AUTHORIZED TO RELEASE RECORDS_____

DATE_____/_____/_____ WITNESS_____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.