



DISORDERS CENTER OF VIRGINIA

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Release of Medical Records

I authorize my physician and/or administrative staff to disclose the following protected health information

FROM: Sleep Disorders Center of Virginia
 Other Doctor/Facility
Name: _____
Fax: (_____) _____

TO: Sleep Disorders Center of Virginia (check location below)
 Other Party
Name: _____
Address: _____
Fax: (_____) _____

Please name the information to be used or disclosed:
 Any and all medical records
 Only records from these dates of service: _____
 Other: _____

This information is being used or disclosed for the following purposes:
 Treatment
 At the request of the patient
 Other: _____

This authorization shall be in effect for 60 days from date below or on ____/____/____, at which time this authorization expires.

I understand that I have the right to revoke this authorization at any time.

SIGNATURE of patient or personal representative Date

PRINT name of patient or personal representative Date

Patient Date of Birth: ____/____/____

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- 130 Temple Lake Drive, Suite 5 * Colonial Heights, VA 23834 * Tel: (804) 526-3450 * Fax: (804) 520-1809
- 8405 Northrun Medical Drive * Mechanicsville, VA 23116 * Tel: (804) 559-4165 * Fax: (804) 559-3320
- 6500 Woodlake Circle Drive * Midlothian, VA 23112 * Tel: (804) 888-6070 * Fax: (804) 888-6071