Records Request for Release of Protected Health Information

VIRGINIA HEART
Excellence in Cardiovascular Care
2901 Telestar Court, Suite 300, Falls Church, VA 22042
Fax Number: (571) 665-6871
www.virginiaheart.com

Patient Name _____ Medical Record Number _____

Patient Date of Birth _____ Contact Phone Number _____

I hereby authorize Virginia Heart to release or disclose my protected health information to:

☐ Physician ☐ Other _____

Phone Number _____

Fax Number _____

_____
Name of Person or Entity to Receive Information

_____
Street Address City State Zip Code

Information to be Released/Disclosed:

☐ Entire Medical Records ☐ Medical records from _____ to _____

☐ The following test(s)/information only: _____

_____

Purpose:

☐ Personal Use
☐ Physician / Health Care Facility
☐ Consult (2nd opinion)
☐ Legal Purposes
☐ Insurance Purposes
☐ Relocation
☐ Other: _____

Records Disposition (please choose one):

☐ Mail to address above ☐ Fax to fax number above ☐ Release to MyChart

☐ I will pick up the records at the following Virginia Heart office location:

☐ Alexandria Office
☐ Arlington Office
☐ Fair Oaks Office
☐ Fairfax Office
☐ Fairfax Office (Heart Rhythm Center)
☐ Fairfax Office (Sleep Center)
☐ Lansdowne Office
☐ Loudoun Office
☐ Purcellville Office
☐ Reston Office
☐ Stone Springs Office
☐ Vienna Office

I understand that Virginia Heart is not responsible for any subsequent disclosure of protected health information as a result of providing this information to the above-mentioned parties. I further understand that I am not required to disclose to Virginia Heart the reason for this request and that I may subsequently revoke this request, if necessary.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient or Authorized Representative Relationship to Patient

Release expires one year from original date

VIRGINIA HEART USE ONLY: Records Released By: _____