Old Dominion Medical Center

6715 Whittier Avenue, Mclean VA. 22101

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

Allen B. Horne, M.D. Patricia Leighton, N.P. .

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

First Name:	Last Name:	Social Security #:	
Street Address:	City:	State:	Zip Code:

Phone #:	Date of Birth: (MMDDYYYY)	Marital Status (circle one) Single / Married / Divorced / Separated / Widowed

Employer:	Address:	City:	State:	Zip Code:

Occupation:	Work Phone:	Work Status (circle one) FT / PT / Retired	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:	Reason for disclosure:

____ ________________________________

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

NOTE: PURSUANT TO VIRGINIA LAW (VA CODE 8.01-413) A $10.00 PROCESING FEE AND $0. 50 CENTS PER PAGE FOR UP TO 50 PAGES AND $0.25 CENTS PER PAGE EACH ADDITIONAL PAGE WILL BE CHARGED FOR MAINTAINING, RETREVING, REVIEWING AND PREPARING SUCH COPIES. PLEASE ALLOW 14 DAYS FOR PROCESSING.