COASTAL VIRGINIA SPINE & PAIN CENTER

MEDICAL RECORDS REQUEST FORM

I, the undersigned, authorize _____

_____ to release my health information as noted below.

PATIENT INFORMATION

All sections must be completed in order for request to be processed

Patient Full Name: _____Other Names During Treatment? _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone #: (____)_____

Email Address: _____

RELEASE INFORMATION TO:

Coastal Virginia Spine and Pain Center 4525 South Boulevard, Suite 200 Virginia Beach, Virginia 23452	PHONE: 757-227-3820 FAX: 757-226-9021	**ATTN:** _____

Purpose of Request: ☐ Physical Therapy ☐ Procedure Pending ☐ Other/Reason: _____

INFORMATION TO BE RELEASED

Please specify the information to be released:

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Notes ☐ Physical Therapy Notes ☐ Other: _____

Specify Dates of Service: _____

Body Part: _____

☐ **Entire Chart**

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**Required - *Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.*

		Check One		*Initial each line below*
☐ I DO	☐ DO NOT	want information about	*Mental Health released	
☐ I DO	☐ DO NOT	want information about	*HIV Tests and Related information released	
☐ I DO	☐ DO NOT	want information about	*Alcohol and/or Substance Abuse released	
****Other Sensitive Information****				
☐ I DO	☐ DO NOT	want information about	*	
☐ I DO	☐ DO NOT	want information about	*	

STOP ***Please confirm that you have put a <u>checkmark and initialed</u> all of the protected categories above, regardless if they are applicable or not. If this form is incomplete, we may be unable to fulfill this request.***

- This authorization will expire one (1) year from the date appearing above. I understand that I may revoke this authorization at any time by notifying the **COVA Spine and Pain Center** in writing, but if I do, it will not have any effect on the actions the practice took before it received the revocation. _____**(Initials)**
- I understand that under the applicable law, the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard. _____ **(Initials)**

Patient Signature: _____ Date: _____

(Required for all patients 18 years and older)

Signature of Parent or Legal Guardian _____ Date: _____

(Required for all patients under the age of 18 unless allowed by law. If not the parent, legal representation documentation must be supplied)