VIRGINIA ARRHYTHMIA CONSULTANTS

Helping you get your rhythm back

Patient Release of Medical Information Request

Patient Name: _____ Date of Birth_____

SSN: _____

Information to be released from: _____

Information to be released to: Virginia Arrhythmia Consultants Fax: (804)272-3409

Information Requested (check all that apply):

_____Last office note

_____H&P and/or Consultation note and Discharge Summary

_____Progress Notes for the last _____ visits / months

_____Lab/Imaging Results (as Specified) _____

_____ Procedure Notes

_____ Operative Summary

_____Other: _____

I hereby request and authorize that the above information be provided to the person or business listed above.

_____ Date _____
Signature of Patient/Requestor*

*If signed by someone other than the patient, please provide the following information:

_____ _____
Name of Requestor Relationship to Patient

NOTE: There will be a $20 pre-payment charge for all forms that need to be completed by a VAC physician. Due to the high volume of forms we receive, please allow 7 business days to get the form back to you. Please fill out any patient specific sections prior to submission to VAC. All forms need to include instructions as to where to send the forms once completed, along with a self-addressed stamped envelope if they are to be mailed.
There will be a charge for copies of records for personal, legal or insurance purposes.

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