VCOM Sports & Osteopathic Medicine
1691 Innovation Dr, Ste 2100 Blacksburg, VA 24060
Ph: 540-232-8405 Fax: 833-464-3281

**Obtain Medical Records Form**

Patient Name:_____ Date of Birth:_____

I, _____, authorize VCOM Sports & Osteopathic Medicine to obtain copies of my records from the following:

Person, Physician or Organization: _____
PHONE NUMBER: _____
FAX NUMBER: _____

Portion(s) of records to be released include (please check desired items to be released):

- o Office Notes: Labs/Studies:
- o Radiology Reports: Other:
- o Sensitive Information (examples include: STD Testing, HIV testing, etc)

This purpose of this disclosure is:

- o Personal Records Continuity of Care
- o Transfer of Care Insurance Processing
- o Legal
- o Other: (please describe): _____

I understand that my records are confidential and may be disclosed only as authorized in this consent or as required by law. I also understand that this is revocable by me at any time except that action has been taken in reliance on this consent.

Signature: _____ Date: _____

Relationship to patient: _____

Unless otherwise specified below, this consent will automatically expire after one year from the date above.
Signature: _____ Request consent to expire: _____