



1691 Innovation Dr, Ste 2100 Blacksburg, VA 24060  
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**Medical Records Release Form**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_, authorize VCOM Sports & Osteopathic Medicine to **release my records** to 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):

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

This purpose of this disclosure is:

- Personal Records \_\_\_\_\_ Continuity of Care \_\_\_\_\_
- Transfer of Care \_\_\_\_\_ Insurance Processing \_\_\_\_\_
- Legal \_\_\_\_\_
- 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: \_\_\_\_\_