**Sanjai C. Rao, DO**
**Phone (804) 322-7800/ Fax (833) 637-1610**
**www.vacns.com**

**5102 West Village Green Drive**
**The Grove 2, Suite 109**
**Midlothian, VA 23112**

# Authorization for Release of Medical Information

Patient Name: _____DOB: ____/____/_____

Parent/ Legal Guardian Name: _____

I, _____ hereby authorize the release of medical information TO:

Virginia Child Neurology Specialists
5102 West Village Green Dr, Suite 109
Midlothian, VA 23112
Phone: 804-322-7800 **Fax: 833-637-1610**
*Preferred method to receive records is via fax

FROM:
Doctor/Clinic/Hospital:_____
Address: _____
Telephone: _____ Fax : _____

Please release the following:
___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam ___ Diagnostic Test Reports and Radiology/Images
___ Discharge Summaries ___ Lab Results and Pathology Reports
___ Growth Charts ___ Consultation Reports
___Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure:
___ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____Date: ____/____/____

Print Name: _____

Relationship to Patient:_____