**Sanjai C. Rao, DO**
**Phone (804) 322-7800/Fax (866) 493-2897**
**www.vacns.com**

**5102 West Village Green Drive**
**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: (866) 493-2897**
*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:_____