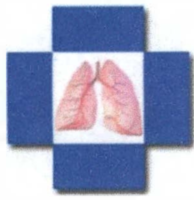
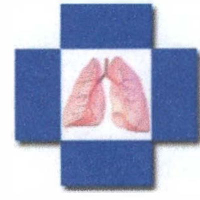


PULMONARY AND CRITICAL CARE SPECIALISTS
of NORTHERN VIRGINIA, P.C.



RELEASE OF INFORMATION

I authorize the physicians and staff of Pulmonary and Critical Care Specialists of Northern Virginia, P.C. to speak with the individual(s) listed below regarding my medical care.

_______________	_______________	_______________
Name	**Relationship to Patient**	**Telephone #(s)**
_______________	_______________	_______________
Name	**Relationship to Patient**	**Telephone #(s)**

In the event of an emergency I authorize the following person(s) be contacted.

_______________	_______________	_______________
Name	**Relationship to Patient**	**Telephone #(s)**
_______________	_______________	_______________
Name	**Relationship to Patient**	**Telephone #(s)**

I authorize ________________________________ **to release my medical records**
(Name of Physician)
as described by the following: ________________________________

To: ____
(Name of Recipient) *(Telephone #)*

____
(Address of Recipient) *(Fax #)*

Medical information released is for use only by the recipient named above; it may not be disclosed to any other individual or agency without my consent or otherwise provided by law. This authorization may be revoked at any time except to the extent that the healthcare provider has already taken action on it.

Patient: ________________________________ **Birth Date** ____/____/______
(Last Name) *(First Name)*

Patient Address: ________________________________

________________________________ **Patient Telephone #** ______________

Patient Signature: ________________________________ **Date** ____/____/______

Witness: ________________________________ **Date** ____/____/______

Request Completed By: ________________________________ **Date** ____/____/______

NOTE: Please print and bring to your appointment.