Virginia Integrative Medicine

901 Preston Avenue, Suites 402, Charlottesville, VA 22903
Phone: (434) 984-2846 Email: info@healthyvim.org

Medical Records Release Form

To request release of medical information please complete and sign this form and either print and send or save and email to the above address/email.

Patient Information (please print clearly)
Last Name _____ First Name_____ MI ___
Street Address _____ Apt #_____
City _____ State_____ Zip _____
Home Phone _____ Alternate Phone _____
Date of Birth _____ Email address _____
Virginia Integrative Medicine has my permission to release the following information contained in the Medical Record of the above named patient.
☐ Most recent Health Summary
☐ Latest Progress/Provider notes
Virginia Integrative Medicine will provide the information requested to the following party (info will be faxed unless otherwise instructed)
Name _____
Attention of _____
Fax number _____ Phone number _____
Street Address _____
City _____ State _____ Zip _____

I understand that my medical records are protected under the State and Federal confidentiality regulations. Disclose of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing or treatment for HIV/AIDS, and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial the appropriate box below if you DO NOT want any of the following records released. All applicable records will be released if nothing is marked.

- ☐ Drug and/or alcohol abuse, diagnosis, or treatment
- ☐ HIV/AIDS testing and/or treatment
- ☐ Psychiatric care and/or mental illness
- ☐ Confirmed STI test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

Signature of Patient _____ Date _____

_____Relationship_____ Date _____

Signature of Parent or Guardian (if minor)