



## AUTHORIZATION FOR THE RELEASE OF INFORMATION

---

I authorize the release of my medical records to Cardiology of Virginia, Inc.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Month) (Day) (Year)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_

*(To Our Patient: This authorization will be placed in your record and accessed in the event that our physicians need medical records from another physician, hospital, or medical facility.)*

Records requested from:  
(This information will be completed when required.)

---

---

---

Please fax records to:  
**(804) 525-2525**

**Cardiology of Virginia, Inc.**

13572 Waterford Place, Midlothian, VA 23112

**Please call us with any questions.**

**(804) 560-8782**

**Thank You!**