SHENANDOAH VALLEY SURGICAL ASSOCIATES

70 Medical Center Circle, Suite 213, Fishersville VA 22939 540-332-5999; fax: 540-332-5990

Authorization for Release of Medical Information

Print Patient Name _____ **Date of Birth (Mo/Day/Yr)** _____

Street Address _____ **Social Security Number** _____

City, State, Zip Code _____ **Home Phone** _____

I, _____ **, hereby authorize** Shenandoah Valley Surgical Associates **to release**
(Patients Name) (Name of facility)

DATES OF SERVICE: _____

(please check either entire record, electronic record, or other)

_____ Entire Paper Copy of Record

_____ Entire Electronic Copy of Record

_____ Other (please specify) _____

____ I do _____ I do not _____ N/A authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE: _____

Please provide current telephone number in the event we need to contact you: _____

_____ _____
Signature of individual or guardian or Personal Representative **Date**

_____ _____
Signature of witness **Date**

THIS AUTHORIZATION WILL EXPIRE 6 MONTHS FROM THE DATE IT WAS SIGNED