

**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 \_\_\_\_\_ 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:**

\_\_\_\_\_  
Shenandoah Valley Surgical Associates  
**Name of Company/Agency/Facility/Person**

\_\_\_\_\_  
70 Medical Center Circle Suite 213  
**Street Address**

\_\_\_\_\_  
Fishersville, VA 22939  
**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**