Central Virginia Neurology

CONSENT TO RELEASE MEDICAL INFORMATION

Date:_____

Patient Name:_____ DOB:_____

Address:_____ SS#:_____

I hereby authorize the release of any medical information, including diagnosis and records, of any treatment rendered to me during the time period of _____ to _____.

The disclosure of records is authorized for continuation of medical care. Such disclosure can be revoked by me at anytime except when disclosure has already taken place. If not revoked this consent will terminate on _____.

Choose from list below of what information is being requested:

____ The last 2 office notes as well as initial office note (other physicians often find this sufficient and this is commonly requested).
____ Office notes and testing up to one year old from today's date.
____ All office notes and testing ordered by this practice.
____ Tests Only (example: MRI scans, CT scans, lab reports and other miscellaneous testing).
____ Other (be specific):_____

Authorize to disclose **TO / FROM**:_____

Address: _____

Phone:_____ Fax: _____

Authorize to disclose **TO / FROM**:

____ Dr. Edward M. Leaton ____ Dr. Richard E. Waller

14355 Sommerville Court
Midlothian, Va 23113
804-379-7721
Fax 804-379-7699

Please note that the copies may be mailed or faxed based upon the request. There is a search and copy fee of $10.00. There is also a charge of $.50 per page for pages of 1-50, and a charge of $.25 per page for pages 51 & up. A bill will be sent out within 5 business days outlining the exact amount due for copying the records. We do require prepayment prior to sending the copies out. Once your payment is received the copies are sent within 5-7 days. If your request is urgent, please inform us of this when you return the payment. If you have circumstances which prevent you from prepaying, please call the office promptly and we will gladly work out a payment plan.

*Signature:_____ Date: _____

Date copied:_____ Date payment rec'd:_____ Date copies sent:_____