



Donna L. Musgrave, M.D.
Margaret Grove, M.D.
Lynn M. Keene, M.D.
Dianna L. Curtis, M.D.

Eric D. Swisher, M.D.
Elizabeth R. Martin, M.D.
Jill M. Arliss, M.D.
Jill A. Gaines, M.D.

Mark W. Chewning, M.D.
Jamie Buck, M.D. Stephanie
Quinn-Philipot, NP

21 Highland Avenue SE, Suite 200 • Roanoke, VA 24013 Telephone (540) 982.8881 • Facsimile (540) 982.0612

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification:

Printed Name _____ Birthdate ____/____/____
Address _____ Social Security ____-____-____
_____ Phone number (____) ____-____

INFORMATION TO BE RELEASED BY:

INFORMATION TO BE RELEASED TO:

Physician or Facility

Street Address

City, State, Zip
(____) ____-____
Phone Number
(____) ____-____
Fax

Physician or Facility

Street Address

City, State, Zip
(____) ____-____
Phone Number
(____) ____-____
Fax

INFORMATION TO BE RELEASED – COVERING THE PERIODS OF HEALTH CARE:

From (date) ____/____/____ To (date) ____/____/____

Please check type of information to be released:

- Complete Health Record
- Pathology Report
- Laboratory Test Results
- Complete Billing Record
- Radiology Report
- EKG Report
- Other (please specify) _____

Purpose of request:

- Treatment or Consultation
- At Patient's Request
- Billing Claims or Payment
- Other (please specify) _____

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, which include the cost of supplies and labor; and postage related to the production of my information. First 25 pages, \$.50 per page, \$.25 each additional page. Payment must be made before records are copied.

Signature of Patient or Legal Guardian _____ Date ____/____/____

Printed Name of Patient _____

Witness _____

**FORMS WILL BE READY IN FIVE (5) BUSINESS DAYS FROM DATE RECEIVED
IF THIS FORM IS NOT COMPLETELY FILLED OUT IT WILL CAUSE A DELAY**