2079 Daniel Stuart Sq.
Woodbridge VA. 22191
(703) 491-5600 Fax: (703) 491-1744

8140 Ashton Ave., Suite 105
Manassas VA. 20109
(703) 396-9000 Fax: (703) 396-9100

125 Hospital Center Blvd, Suite 317
Stafford VA. 22554
(540) 318 8201 Fax: (844) 463-3895

CONSENT FOR RELEASE OF HEALTHCARE INFORMATION FORM

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of this information.

Patient Name: _____

Previous Name: _____

Date of Birth: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

NORTHERN VIRGINA HEMATOLOGY AND ONCOLOGY ASSOCIATES

The request and authorization apply to:

[ ] Healthcare information relating to the following treatments, conditions, or dates

_____

[ ] All Healthcare Information

[ ] Other_____

This release of information will remain in effect until terminated by me in writing. Patient Initials: _____

Patient Signature: _____ Date: _____