Medical Records Release of Information. This Authorization must be fully completed and signed:
Return this form to Attn. Release of information: P.O. Box 20505; Roanoke, Va 24018 • Phone: 540-446-2436;

I, Patient Name:_____. Patient's Phone:_____

Date of Birth:_____ SSN:_____, am requesting records for the following

Requested Dates of Service: _____. I request ☐Medical Records and or ☐Billing Records for

Facility Name(s): ☐ Avvocado Car Accident Followup Care, LLC. ☐Home Physical Therapy Health, LLC
☐Roanoke Cognitive Care, LLC ☐Imaging Services, LLC (Without Imaging) ☐Add Imaging Disc ($35)

To be mailed to, Recipient's Name: _____

Recipient Address:_____ City:_____

State:_____ Zip Code:_____ Recipient's Phone:_____

Recipient's Email:_____ Recipient's Fax Number: _____

Purpose of disclosure: ☐ Individual (Patient); Other 3rd party recipient (please specify purpose): ☐ Attorney ☐ Medical

☐Other (Please specify)_____

There is some level of risk that a third party could see your information without your consent when releasing protected health information to anyone other than the patient. We are not responsible for unauthorized access to the PHI.
This authorization will expire after 180 days or on the following (please choose only one):

Expiration Date: _____Expiration Event: _____

All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information.
I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. I understand that the released information may not be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient/Patient's Rep. Signature:_____Print Name: _____