HEALTHCARE ON THE SQUARE
P.O. Box 540
Boydton, VA 23917
Phone: (434) 738-6102
Fax: (434) 738-6982

Records Transfer Request

Date: ___________

Patient's Full Name: ______________________________________ DOB: ___________

I hereby authorized HealthCare on the Square to (circle) **Obtain From** or **Release To**

Physician's Office: ____

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* A report of lab results, x-ray reports, diagnosis, treatment, prognosis, and recommendations as well as other data pertinent to your treatment of me from ___________ to ___________.

or all records regarding ____

* Please release all clinical history and records: _____________________________

Medical information is protected under law and will not be released without written consent. Information released with this authorization will not be given, sold, transferred or in any way relayed to any other person not specified above.

This consent will expire one year from the above date unless otherwise specified.

____ __________________
Signature of Patient Date

____ __________________
Witness Date