Commonwealth of Virginia
Department of General Services
Division of Consolidated Laboratory Services
Richmond, Virginia

Authorization and Consent for the Release of Medical Records

SECTION 1: Patient Information at time of testing
(*Please print***):**

First Name	Last Name	Middle Initial

Sex (Circle one)	Date of Birth	Phone number (XXX-XXX-XXXX)
Male Female		

Address Street, Apt. #	City	State	Zip Code

Mother's Full Name (*Newborn Screening only)*	Physician of Record at the Time of Collection

SECTION 2: Authorization of Release:

Laboratory Report type(s):_____Approximate specimen collection date: _____

Send report to: _____
_____

I hereby authorize the Department of General Services, Division of Consolidated Laboratory Services, Richmond Virginia, 23219, to release, disclose and deliver the result(s) indicated above. Please be aware this request may take up to thirty days to process and deliver.

Re-disclosure: This release does not authorize re-disclosure of medical information beyond the limits of this consent. The recipient of this information is to only use the information for the stated purpose, and is prohibited from disclosing it to any other party without further authorization. This is a onetime authorization.

SECTION 3: Validity: I authorize the release of information as indicated above

_____
Date **Patient Name** (*Print)* **Signature**

_____
Date **Parent/Guardian /Power of Attorney** (Print) **Parent/Guardian/Power of Attorney** (Signature)

_____
Relationship to Requestor

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SECTION 4:
Given under my hand and seal of office this _____month, day of_____, _____ (year)

_____
Notary Public's Signature

(Personalized Seal):