

CENTREVILLE OB/GYN
14701 LEE HWY, SUITE 304
CENTREVILLE, VA 20121
703-830-4388 | 703-830-4188 (f)



RESTON WOMEN'S CENTER
1850 TOWN CENTER PKWY,
SUITE 650, PAVILION II,
RESTON, VA 20190
703-955-5978 | 571-267-7903(f)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Full Name: _____ Date of Birth: _____

Previous Name: _____ Social Security#: _____

I request and authorize _____

To release healthcare information to the following parties:

Name: _____ **Centreville OB/GYN**

Address: _____ **14701 Lee Hwy, Suite 304, Centreville, VA 20121**

Phone: _____ **(703) 830-4388** Fax: _____ **(703) 830-4188**

This request pertains to the following information:

All healthcare information

Other: _____

Yes No I authorize the release of STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above

Patient Signature: _____ Date Signed: _____