



14051 St. Francis Blvd. Suite 2210
Cancer Institute Building
Midlothian, VA 23114



Phone 804-594-3130

Fax 804-594-3131

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

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

Name: Virginia Breast Center, Bon Secours Medical Group
14051 St Francis Blvd, Suite 2210
Address: Cancer Institute Building
City: Midlothian State: VA Zip Code: 23114

This request and authorization applies to:

All healthcare information

Other: _____

Yes No

Patient Signature I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.