Glenside Medical Associates, P.C.

4000A Glenside Drive
Richmond, VA 23228
(804) 262-4763

RELEASE OF INFORMATION REQUEST

I _____ (authorize) (do not authorize)
(PATIENT NAME)
Glenside Medical Associates, P.C. to discuss any information pertaining to Lab results, Diagnosis, Health Insurance, Insurance Referrals, and Billing issues with the person(s) listed below. I also authorize the person (s) listed below to obtain any of my written prescriptions and/or prescription samples.

I _____ (authorize) (do not authorize)
(PATIENT NAME)
Said persons to obtain prescriptions, X-rays and/or samples.

_____ _____.
(PERSON(S) TO RELEASE INFORMATION) (RELATIONSHIP TO PATIENT) (DATE OF BIRTH) (VERIFICATION)

_____ _____.
(PERSON(S) TO RELEASE INFORMATION) (RELATIONSHIP TO PATIENT) (DATE OF BIRTH) (VERIFICATION)

Please list any special instructions and/or exceptions:

_____ _____.
Signature (Patient) **Effective/Authorization Date**

_____ _____.
Glenside Medical Assoc. Representative **Date**

YOU MAY REVOKE THE ABOVE AUTHORIZATION TO RELEASE YOUR INFORMATION AT ANY TIME WITH WRITTEN NOTICE.