MOUNTAIN VIEW
INTERNAL MEDICINE & PEDIATRICS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ DOB:_____

I authorize

Practice Name: _____

Address: _____

Fax number: _____

To release healthcare information **to**

Mountain View Internal Medicine and Pediatrics

7051 Heathcote Village Way Suite 155

Gainesville, VA 20155

FAX: 571-248-1073

This authorization includes **all healthcare information**, unless otherwise noted below:

Yes No STD and/or HIV/AIDs testing

Yes No Drug, Alcohol, or mental health treatment

Patient Signature: _____ Date:_____