Fredericksburg
Womens Health Associates
1300 Hospital Drive
Suite 300
Fredericksburg, VA
22401
(540) 656-2830 Office

Request to Release Medical Information

To Caregiver or Family Member

Today's Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

Address: _____

_____

Phone Number: _____

I give permission to Dr. Leonard, Associates and staff to release my medical information to:

Name: _____

Relationship to Patient: _____

Address: _____

_____

Phone Number: _____

(sign here)

_____

Signature of patient or legal representative