

Mid-Atlantic Family Medicine

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Medical Records Release Authorization

To: _____

Address: _____

I hereby authorize you to release my medical records, including operative reports, radiology reports, pathology reports, and discharge summaries to:

Christopher W. Asuncion, M.D. and/or

Shannon M. Morris, PA-C

Mid-Atlantic Family Medicine

828 Healthy Way, Suite 350

Virginia Beach, VA 23462

(757) 705-5265

(757) 962-2884 fax

Print Name of Patient: _____

Patient's Complete Current Address: _____

Signature of Patient: _____

Patient's Date of Birth: _____

Date: _____

Expiration Date: _____

(If none, write "none")