



**WADDELL FAMILY MEDICINE, PC**

DAVID T. WADDELL, MD, CCD, ABFM

FAMILY MEDICINE FOR AGES 6 AND OLDER

TELEPHONE (757) 962-6262  
FACSIMILE (757) 962-1185  
WWW.WADDELLFAMILYMEDICINE.COM

1000 FIRST COLONIAL ROAD, SUITE 101  
VIRGINIA BEACH, VA 23454

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

RELEASING PHYSICIAN'S NAME \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

WADDELL FAMILY MEDICINE, PC  
DAVID T. WADDELL, MD  
1000 FIRST COLONIAL ROAD, SUITE 101  
VIRGINIA BEACH, VA 23454  
TELEPHONE: 757-962-6262  
FACSIMILE: 757-962-1185

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
FACSIMILE: \_\_\_\_\_

CHOOSE ONE:

PLEASE INCLUDE MY COMPLETE MEDICAL RECORD.

OR

PLEASE INCLUDE THE PROBLEM LIST, MEDICATION LIST, IMMUNIZATION RECORD AND ALL LABS AND OTHER TEST RESULTS FOR THE PAST TWO YEARS.\*\* (RECOMMENDED)\*\*

OR

PLEASE INCLUDE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN DATE: \_\_\_\_\_

\*THIS AUTHORIZATION IS VALID FOR 12 MONTHS FROM THE DATE ABOVE. YOU MAY CANCEL THIS -- REQUEST WITH WRITTEN NOTIFICATION AT ANY TIME.

\*YOUR PRIOR PHYSICIAN OR THEIR AGENT MAY CHARGE YOU A COPYING FEE.

\*THIS AUTHORIZATION IS VOLUNTARY AND THE ABILITY TO OBTAIN TREATMENT WILL NOT BE AFFECTED IF YOU DO NOT SIGN THIS FORM.