Consent to Release Medical Information

To: ____

I, __________________________________, hereby give my permission for APT Virginia (provider) to receive my records/ radiographs including the dates of treatment from ____________________ to _____________________- specifically all information you may have regarding my condition when under your observation or treatment, including history, findings, diagnosis, all radiographs and subsequent of further development.

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In the event that I wish to revoke the authorization in the future, I will submit in writing my desire to do so to APT Virginia.

Print Name: _____________________________ Date: ______________________________

Signature: _______________________________ Date of Birth: ________________________

Witness: ________________________________ Social Security #: ______________________