STATELINE Health

RECORD RELEASE (to Stateline)

Patient Name: _____ DOB:_____

Address: _____

Phone Number: _____ SSN:_____

Information to be released TO: **Stateline Health**
435 Commonwealth Blvd. E.
Martinsville, VA 24112

Phone: 276-403-4278 Direct Fax: 276-403-4283 EMR Fax: 276-403-4279

Information to be released FROM: Facility Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Dates Requested: _____
Purpose of request:
Changing providers _____ Relocation _____ Referral _____ Other _____
Specific Information requested:
_____
_____

I certify that this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless provided for by state and federal law. A copy of this original shall be as legally binding as the original and may be accepted by the health care facility in lieu of the original.

I understand I may revoke this authorization at any time. Except to the extent that actions have already been taken. If not previously revoked, this consent shall expire one year from the date signed.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____