

**CONSENT TO RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION**

Patient Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Person, Agency, or Provider to Whom Disclosure is to be made: **Anshu S. Guleria, M.D.**  
8525 Rolling Rd. Suite 220  
Manassas, VA 20110  
(703) 393-0700  
(703) 393-0661 FAX

Information or Records to be Released: All original medical records concerning my care and treatment, including, but not limited to, histories, examination, diagnoses, prognoses, prescriptions, x-rays, laboratory tests and accounting records relating thereto.

As the person signing this consent, I understand that I am giving my permission to the above-named provider for the release of confidential health care records as set forth above, pursuant to Va. Code § 32.1-127.1:03. A copy of this consent shall be included with the original records delivered pursuant to this consent.

The person who receives the medical records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
(Print Name of Patient)

\_\_\_\_\_  
Social Security Number

Date \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
(Print Name of Witness)

Date \_\_\_\_\_