



603 Pilot House Dr. Suite 240
Newport News Virginia 23606
P: 757-873-0138 F: 757-873-0246
www.hancockvein.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ SSN: _____

I request and authorize

to release healthcare information for patient named above to:

Susan M. Hancock, M.D.
603 Pilot House Dr, Suite 240
Newport News, VA 23606
P: 757-873-0138 F: 757-873-0246

This request and authorization applies to:

____ Healthcare information related to the following treatment, condition, or dates:

____ All healthcare information
____ Other: _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____