



John E. Brady, MD

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I the above named person, request:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

To release my health care information to:

Name: THE Village Doctor

Address: 10222 WARWICK BLVD

City: NEWPORT NEWS State: VA Zip Code: 23601

This request and authorization applies to:

Health care information relating to the following treatment, condition or dates: _____

All health care information

Other: _____

This release expires 60 days after date signed

Patient Signature: _____ Date Signed: _____