



4548 Empire Court
Fredericksburg, VA 22408
(540) 373-2244 FAX (540) 371-4849

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

| | |
|--|--|
| PATIENT NAME AT TIME OF TREATMENT | SSN: _____ DAYTIME PHONE: _____ DOB: _____ |
|--|--|

Reason for Request: Copy for own use Continuing Care Moving Legal Other, _____

Release Information To: Organization/Name: _____
Address: _____
Phone/Fax: _____

RECORDS REQUESTED (Charges for Copies of Records may be associated with your request)

Health Information related to Condition: _____
 Records Associated with Date Range: _____
 Office Notes
 Operative Notes
 Other: _____

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the practice. Rediscovery of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express written revocation, the authorization will automatically expire upon initial release of medical records, unless indicated differently below:

Date: _____ **Signature:** _____

If signature is different from patient, please note authority to sign: POA Administrator for Deceased Parent of Minor (Note: POA and Administrator for Deceased will require authenticating documentation prior to release of records)

Office Use Only

Identification Verified by: Driver's License Picture ID, Other: _____ Other: _____

Fee: \$ _____ **Released by:** _____

Records Sent Via: US Mail Fax Pickup by Patient Other, _____ **Date:** _____