

Medical Records Request

- This is to authorize Virginia Physicians for Women **to release** all medical information including the diagnosis and records of any treatment or examinations rendered during the period from _____ to _____.
(There will be a \$20 fee for a paper copy or \$15 for a USB Flash Drive.)

Mail to address: _____

***Before giving your records to another physician, please make a copy to keep for yourself.**

- I am authorizing Virginia Physicians for Women **to obtain** my medical records from the following entity:

Please release my medical records to:
Virginia Physicians for Women
10710 Midlothian Tnpk., Ste. 200
Richmond, VA 23235
PH 804-897-2100
FAX 804-897-2107

Patient Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ SSN: _____

Reason for leaving the practice: _____

As the person signing this consent, I understand that I am giving my permission to the above named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included in my original records. The person who receives the 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 disclosure permitted by law.

Patient Signature _____ Date _____

- Please check here if you prefer to receive your records on a USB Flash Drive for a \$15 fee.
- Please check here if you prefer to receive your records as a paper copy for a \$20 fee.

Location for Pick up _____

