

Medical Records Request on USB Flash Drive

This is to authorize Virginia Physicians for Women to release my complete medical record, including the diagnosis and records of any treatment or examinations. I wish to receive these records on a USB Flash Drive for a \$15 fee. To pick up at:
 Midlo Tpke St Francis Col Heights Henrico Drs St Marys Innsbrook

I elect to have the Flash Drive mailed to me for an additional \$5 shipping and handling fee.

Please submit this request to Virginia Physicians for Women by one of the following methods:

By mail Virginia Physicians for Women
 10710 Midlothian Turnpike
 Suite 200
 Richmond, VA 23235

By fax 804-897-2107

By email medrec@vpfw.com

Patient Name: _____

Address: _____

City, State, Zip _____

Date of Birth: _____ SSN: _____

As the person signing this consent, I understand that I am giving my permission to the above named provider or other named 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 _____ Revised 8/18/09