# 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 _____.

Mail to address _____

_____

or Fax to: _____

☐ I am authorizing Virginia Physicians for Women to obtain my medical records from the following entity:
(Please be aware that the entity listed below may charge you a fee to release these records.)

_____

_____

_____

Please release my medical records to:
Virginia Physicians for Women
10710 Midlothian Tnpk, Ste 200
North Chesterfield, 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.

I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
Special Instructions: _____

Patient Signature_____ Date _____

*This authorization shall be in effect until the information has been forwarded as requested.*

☐ *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.

☐ Please check here if you prefer to receive your records via patient portal at no charge. (Must be a registered portal user for this option. Please request portal invite from our staff. Please provide email address_____)