virginia physicians FOR WOMEN

Medical Records Request & Release Form

☐ This is to authorize Virginia Physicians for Women **to RELEASE** all medical information including the diagnosis and records of any treatment or examinations during the period from _____to_____.

Office/Provider Name and Address: _____

_____

Please provide FAX #: _____

☐ 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
1212 Koger Center Boulevard
N Chesterfield, VA 23235
PH 804-897-2100
FAX 804-897-2107

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 third party for disclosure of the 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 medical records. A copy of this consent and 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.

☐ Dates of service after 3/11/25 are automatically available on your patient portal at NO CHARGE.

☐ Please check here if you prefer to receive your records via secure email at no charge.
EMAIL ADDRESS: _____

☐ Please check here if you prefer to receive your records as a **paper copy for $0.25 per page plus postage/handling**.