Virginia Women's Health Associates

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RECORDS RELEASE REQUEST

Date: _____

Patient Name: _____ DOB: _____

I hereby request that all my medical records be released **to/from (please circle one)**:

_____
Practice/Provider's Name (or if to be released directly to you, write "self")

_____
Mailing Address

_____
City, State and Zip Code

_____
Phone Number **(required)** Fax Number

I can be reached at _____ if there are any questions regarding this request. I understand that there is a $30 handling fee. Once we have received payment we will process your request. Please be advised that it takes up to 10 business days to process. Under the privacy rules, I have the right to revoke this authorization at any time. I also understand that by disclosing my medical records, Virginia Women's Health Associates cannot guarantee the recipient will not use or disclose records in violation of the Privacy Rules.

The purpose/reason for request is: _____

_____ _____
Patient Name/Authorized Representative Signature of Patient/Authorized Representative

_____
Description of Personal Representative's Authority