1625 North George Mason Dr.
Suite 474
Arlington, VA 22205
Phone: 703-528-6300
Fax: 703-525-1967

1875 Campus Commons Dr.
Suite 110
Reston, VA 20191
Phone: 703-437-8080
Fax: 703-525-1967

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ______________________________ Date of Birth: ______________
Address: ______________________________ Phone: ______________
City, State, Zip: ______________________________ Account Number: ______________

I AM REQUESTING MY RECORDS *FROM HEALTHCARE FOR WOMEN*

I understand that Healthcare For Women will provide this information within 10 business days from receipt of this request. I understand that I am financially responsible for the following fees associated with my request: copying of records, including the cost of supplies, labor, handling, and postage if records are to be mailed. I understand that the charge for this service based on Virginia State Law (VA Code 8.01-413) is; $.50 cents per page up to 50 pages then $.25 cents a page thereafter plus $10 handling fee and postage charge based on USPS fees.

I am requesting a copy and/or authorizing the release of the following:

Complete Medical Record File
Disability Forms / FMLA / Return to Work Forms (Fee of $35 applies for completion of forms)
Lab Results / Reports / Visit Notes from Following Dates: ______________________

Please send records to:

Address listed above   Pick Up in Office
Doctor/Company: ______________________________ Phone: ______________
Address: ______________________________ Fax: ______________
Email (Records must be 15 pages or less): ______________________________

I AM REQUESTING RECORDS *FROM PREVIOUS DOCTOR/HOSPITAL:*

I request a copy of my medical records from the following doctor/hospital:
Doctor: ______________________________ Phone: ______________
Address: ______________________________ Fax: ______________
____
Please release the following: ______________________________

I hereby authorize Healthcare For Women to use and disclose Protected Health Information (PHI) as described above. I understand that if the organization authorized to receive the information is not a health provider and they disclose my PHI, it may no longer be protected by federal privacy regulations. I also understand this authorization is valid for 30 days only and may be revoked in writing at any time, but it won't have any effect on any actions taken prior to revocation.

I certify that I have read, signed and received a copy of this authorization upon my request.

X ______________________________   ______________

Signature of Patient   **Date**

Office Use:Total Fee: ______________	Date Received Request/Received By: ______________
Date Mailed/Faxed/Patient Picked Up: ______________	Prepared By: ______________