

1625 N. 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 hereby request and authorize for Healthcare For Women to release my records indicated:
Information to be released:

- Complete Medical Records
- Disability Forms / FMLA / Return To Work Forms (Fee of \$35 applies for completion of forms)
- Lab Results/Pathology Results From Following Dates: _____
- Office Notes From Following Dates: _____
- Radiology Reports From Following Dates: _____

I SPECIFICALLY AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

- Mental Health
- HIV Related Information (AIDS related tests)
- Substance Abuse (including alcohol/drugs)

Signature: _____

PLEASE SEND RECORDS TO _____ :

- Address listed above
- Pick up in office
- Doctor/Company: _____ Phone: _____
Address: _____ Fax: _____

PURPOSE OF DISCLOSURE:

- I AM MOVING
- I AM TRANSFERRING PRACTICES. REASON: _____
- CONTINUING CARE/PERSONAL RECORD
- I AM AN OB PATIENT, LEAVING THE PRACTICE. REASON: _____

I hereby authorize Healthcare For Women to use and disclose my Protected Health Information (PHI) as described above. I understand this authorization is valid for 180 days only and may be revoked in writing at any time, but it will not have any effect on any actions taken prior to revocation. I understand that HCFW will provide the information requested within 10 business days from receipt of this request. I understand that I am financially responsible for the fees associated with my request based on Virginia State Law (VA Code 8.01-413) \$0.50 cents per page up to 50 pages, \$0.25 cents per page there after plus \$10 handling fee and postage charged based on USPS fees.

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

_____ Date _____ Signature of Patient

Office Use: Total Fee: _____	Date Received Request/Received By: _____
Date Mailed/Faxed/ Picked Up/Email: _____	Prepared By: _____