431 Park Avenue
Suite 300
Falls Church, VA 22046
Phone: 703-528-6300
Fax: 703-525-1967

Healthcare For Women
OBSTETRICS and GYNECOLOGY

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 TRANSFERING 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)
For written copies: $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.
For digital copies: $0.37 per page up to 50 pages $0.18 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:** _____