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Medical Records Release (From About Care OB/GYN)

FROM:

Patient's Name: _____ Date of Birth: _____
Date of Request: _____ (For Office Use: Charts: _____
Address: _____
City: _____ State: Zip: _____

RELEASE TO:

I hereby authorize the release of copies of my results from blood tests, radiology, pathology, or
(Specify type of records): _____
and request that they be forwarded to: myself or the entity listed below:

Name: _____
Address: _____
Signature: _____ Date: _____

*If you would like a copy of records in our possession from another physician, please sign here:
Signature: _____ Date: _____

We require a fee for copying and handling. Our fee is in accordance with Virginia law (Section 8.01-413, 32.1-127, 1.03 and 54.1-2403.3 of the Virginia Code.)

Handling \$10.00

Total number of pages	_____ pages		FOR OFFICE USE
\$0.50 per page up to 50 pages	_____ pages		
\$0.25 per page thereafter	_____ pages		Records
			mailed faxed
For a copy of records in our possession from physicians, your			picked up
fee for copying these additional pages is as above:			on ___/___/___
\$_____ per page x _____ pages			by (initials) ____

Once we have received your payment for the above amount, we will process your request. Please be advised that it takes up to 15 business days to complete your request. If you require your records in less than 15 business days, we require an emergency processing fee of \$25, in addition to the regular fee. Your request will be completed within 2 business days. If you have any questions, please do not hesitate to call our office.