Medical Records Request

I, the patient, hereby request that the following medical records:

All Records: _____

☐ Most Recent Pap	☐ Recent Lab Reports	☐ Substance Abuse Information
☐ Most Recent Mammogram Report	☐ Pathology Reports	☐ Most Recent DXA Reports
☐ Most Recent Colonoscopy	☐ Radiology Reports	☐ Surgical Notes

Other, please specify: _____

be released from:

Dr. _____

Address: _____

_____

_____

Phone #: _____Fax #: _____

and sent to the following physician:

Dr. _____

at the Virginia Women's Center location below:

Attn: Centralized Medical Records Office
7130 Glen Forest Drive, Suite 101
Richmond VA, 23226
804.288.4084
804.282.2601

The purpose of this request : ☐ At the request of the individual ☐ Other:_____

I understand that this authorization will be valid for six months.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Virginia Women's Center has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to Virginia Women's Center at the address checked above.

Patient's Signature: _____ **Printed Patient's Name:** _____

Date: _____ **Date Last Seen by Previous Practice:** _____

Date of Birth: _____ **Last Four Digits of Social Security Number:** _____

Reason for Transfer: _____