# WOMEN'S HEALTH AND SURGERY CENTER

YOUR HEALTH • YOUR BABY • YOUR LIFE

2761 Jefferson Davis Highway St. 101 Stafford, Va. 22554
Phone: (540)720-7340 Fax: (540)720-7341

## MEDICAL RECORDS RELEASE AUTHORIZATION

Patient: _____ DOB: _____

Address: _____

Phone: _____

Reason for Request: _____

If transferring, Why? _____

_____

Please have my physician send the following information: (mark all that apply)

- ☐ Complete Record
- ☐ Labs
- ☐ Ultrasound/Sonogram Results
- ☐ Progress Notes

I , _____ ,certify the above request is accurate and hereby authorize the release of these records.

| | | | |
|---|---|---|---|
| From: | _____ | To: | _____ |
| Address: | _____ | Address: | _____ |
| Phone: | _____ | Phone: | _____ |
| Fax: | _____ | Fax: | _____ |

***I agree to pay all fees associated with this release, based on the standard fees outlined below.
I understand that all sections of this form must be completed before it can be processed.***

_____ _____ _____
SIGNATURE OF PATIENT DATE PHONE

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**Virginia law allows for copy charges consisting of the following: $10.00 administrative fee
PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter.**

| | | | |
|---|---|---|---|
| Administration Fee: | $10.00 | Date Copied: | _____ |
| $0.50 per page up to 50 pages: | _____ | Date Released: | _____ |
| $0.25 per page thereafter: | _____ | Employee: | _____ |
| Total Fees: | _____ | | |