

The Physicians & Midwives Collaborative Practice

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Alexandria Virginia, 22304

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Request for Medical Records

I, _____, hereby request and authorize the Physicians & Midwives Practice to release my medical records to:

Myself/Patient Doctor/Practice Other

Please Indicate Name/Practice to whom records will be received by:

My Full Name: _____

Date of Birth: _____

Address: _____

Best Contact Number: _____

Social Security No.: _____

I would like ALL my medical records.

I would like a specific office visit, lab report, or other type of document.

Please Indicate what specific document and date: _____

I am requesting my records because: I am Moving I am transferring practices

Another physician requests it.

Other Reason: _____

I need my medical records by: _____

I would like to pick up my records in person.

I would like my records faxed to: _____

I would like my records be sent by mail to: _____

I understand by signing this document that I am allowing Physician & Midwives to release the stated documents I have requested. I also understand that I am subject to any fees associated with the processing of these records. (Fees will never exceed \$25.00)

My Signature: _____ Date: _____

Witness Signature: _____ Date: _____

****Note: Processing medical records can take up to 15 days from the requested date****