THE PHYSICIAN AND MIDWIFE COLLABORATIVE PRACTICE

4660 KENMORE AVENUE
SUITE 902
ALEXANDRIA, VIRGINIA 22304
TELEPHONE (703) 370-4300
FAX (703) 370-0044

2616 SHERWOOD HALL LANE
SUITE 208
ALEXANDRIA, VIRGINIA 22306
TELEPHONE (703) 780-6900
FAX (703) 780-3418

12508 LAKE RIDGE DRIVE
LAKE RIDGE, VIRGINIA 22192
TELEPHONE (703) 491-1122
FAX (703) 491-1386

5901 KINGSTOWNE VILLAGE PKWY
SUITE 200
ALEXANDRIA, VA 22315
TELEPHONE (703) 922-3434
FAX (703) 921-3889

Request for Medical Records

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

[ ] I would like to pick up my records in person at the following office (Pick one):

[ ] Kenmore Avenue **[ ] Sherwood Hall Lane**

[ ] Lake Ridge **[ ] Kingstowne**

[ ] I would like my records faxed to: ________________________________
[ ] I would like my records sent by mail to: ____
____
____

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 DO [ ] I DO NOT authorize release of information related to AIDS/HIV infection, STD's, psychiatric care and/or psychological assessment, and treatment for alcohol and /or drug abuse.

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

I understand by signing this document that I am allowing Physician & Midwives to release the stated documents I have requested at this time only. I understand that once my healthcare information has been disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected. 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:_____________________

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