REQUEST FOR RELEASE OF RECORDS

I hereby request and authorize that:

NAME OF PHYSICIAN:____

PHONE NUMBER:____

FAX NUMBER:____

ADDRESS:____

RECORDS NEEDED:____

Release of medical records in your possession concerning my overall health care, illnesses and treatments administered to me to:

****PLEASE NOTE: FOR RADIOLOGY REQUESTS, WE DO NOT ACCEPT FILMS – PLEASE SEND REPORT ONLY****

The Physician & Midwife Collaborative Practice
4660 Kenmore Ave Suite 902
Alexandria, Virginia 22304
Tel. 703-370-4300
Fax # 703-370-0044

NAME:____

SIGNATURE:____

ADDRESS:____

CITY, STATE,ZIP:____

TODAY'S DATE:____

DATE OF BIRTH:____

SS# NUMBER:____

WITNESS:________________________________DATE:________________