Request for Release of Medical Records

Hoadly Medical Care	**Hillendale Medical Care**	**Herndon Medical Care**	**Caremed Family Practice**	**Millennium Medical Care Stone Springs**
6356 Hoadly Rd Manassas, VA 20112	13168 Centerpointe Way Suite #101 Woodbridge, VA 22193	1043 Sterling Rd Suite #104 Herndon, VA 20171	11213 Lee Hwy Suite H Fairfax, VA 22030	24430 Stone Springs Blvd Suite 200 Sterling, VA 20166
703-590-5999 703-590-5399 (Fax)	703-730-2000 703-730-6767 (Fax)	703-689-0111 703-689-0077 (Fax)	703-832-8023 703-776-9499 (Fax)	703-665-2027 703-665-2195 (Fax)

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Name of person requesting records: _____

Relationship to the patient: _____

(Note: The person requesting the records must be the patient or Parent/Legal guardian. Medical records may not be given to the spouse or any other person unless legal consent is given from the patient to authorize these records to be released to the requesting person)

Please give a reason for the request of the medical records: _____
_____
_____

Medical records you are requesting:

_____ Entire Medical Record _____ Immunization Record
_____ Diagnostic Results only _____ Other: _____

I, _____ understand that there will be a charge for the release of these records. ($15.00 for copying plus $0.50 per page for the first 50 pages, then $0.25 for the remaining pages. VA. Code Section 8.01-413 (2003))

*Please note that until all account balances including the fee for the release of records are paid, medical records will not be released.

Signature _____

Print Name _____

Today's Date _____