Please note:

Some practices charge for copying and releasing your medical records to our office. The physician's office will either send you a bill or charge you in advance for this service.

The fees shown on the our Medical Records Release Form are fees that we charge for copying records and may not be the same fees charged to you by your previous physician's office.

Please let us know if you have any questions.

Virginia Physicians does not cover the cost for your records to be released to our office. Those costs are between you and your previous physician's office.

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT.

THIS FORM CAN ALSO BE EMAILED TO US AT: MMCFRONTDESK@VAPHYSICIANS.COM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name _____

Date of Birth _____ SSN _____

Home _____ Work _____ Cell _____

Release records to:	**Release records from:**
_____ (physician or facility)	_____ (physician or facility)
_____ (address)	_____ (address)
_____ (city, state, zip)	_____ (city, state, zip)
_____ (phone)	_____ (phone)
_____ (fax)	_____ (fax)

Reason for request: _____

Information to be released:

_____ Completed health records

_____ Office notes - dates from _____ to _____

_____ Immunizations Labs only _____ X-Rays only _____

Other: _____

I Do _____ or I Do Not _____ authorize the release of information related to:

- ☐ AIDS (Acquired Immunodeficiency Syndrome)
- ☐ HIV (Human Immunodeficiency Virus) Infection
- ☐ Psychiatric care and/or Psychological assessment
- ☐ Treatment for alcohol and/or drug abuse

Copying fees for records provided by Virginia Physicians, Inc. are as follows:

$10.00	Processing Fee
$00.50	per page for initial 50 pages
$00.25	per page for each additional page
$25.00	X-Ray films minimum $25.00 for each additional set of three films

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I need not sign this form in order to assure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Patient/Parent/Guardian/Representative _____ Date _____