Request for Medical Records

PATIENT INFORMATION:

____

Name | Address | City | State | Zip Code

____________________________(_________)____

Date of Birth | Daytime Phone | Previous Name used if any

AUTHORIZES:

____

Name of Health Care Provider /Plan / Other

____

Address

TO DISCLOSE TO:

Internal Medicine-Primary Care, 44081 Pipeline Plz , Ste 200, Ashburn, VA, Phone: 703-651-5910, Fax: 562-352-5900

DATE(S) OF INFORMATION TO BE DISCLOSED: From _________________________ to _________________ If left blank, information from the past two (2) years is requested. (month/year) (month/year)

INFORMATION TO BE DISCLOSED:

☐ All medical records related to (specify condition, treatment, etc.): ______________________________
☐ All medical records:
☐ Radiology films/images (specify test): ____
☐ Specific records/information as follows: ____

SIGNATURE OF PATIENT / LEGAL REP: ____________________________DATE: ________________