SURGICAL ASSOCIATES of FREDERICKSBURG

4548 Empire Court
Fredericksburg, VA 22408
(540) 373-2244 FAX (540) 371-4849

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

PATIENT NAME AT TIME OF TREATMENT	**SSN:_____ DAYTIME PHONE:_____** **DOB:_____**

Reason for Request: ☐ Copy for own use ☐ Continuing Care ☐ Moving ☐ Legal ☐ Other, _____

Release Information To: Organization/Name: _____

Address: _____

Phone/Fax: _____

RECORDS REQUESTED (Charges for Copies of Records may be associated with your request)

- ☐ Health Information related to Condition: _____
- ☐ Records Associated with Date Range: _____
- ☐ Office Notes
- ☐ Operative Notes
- ☐ Other:_____

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the practice. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express written revocation, the authorization will automatically expire upon initial release of medical records, unless indicated differently below:

Date: _____ Signature: _____

If signature is different from patient, please note authority to sign: ☐ POA ☐ Administrator for Deceased☐ Parent of Minor (Note: POA and Administrator for Deceased will require authenticating documentation prior to release of records)

Office Use Only

Identification Verified by: ☐ Driver's License ☐ Picture ID, Other:_____ ☐ Other:_____

Fee: $_____ **Released by: _____**

Records Sent Via: ☐ US Mail ☐ Fax ☐ Pickup by Patient ☐ Other, _____ Date: _____