Fair Oaks Urology

3700 Joseph Siewick Dr., Suite 101
Fairfax, Virginia 22033
Phone: (703) 698-1856
Fax: (703) 207-0843
www.fairoaksurology.com

Medical Records Release

WE DO NOT FAX OR EMAIL MEDICAL RECORDS TO PATIENTS

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

The purpose of this request for medical records is: (Check all that apply):

- ☐ Patient's request - Continuation of care/transfer of care/Second opinion
- ☐ Attorney/legal request
- ☐ Insurance – Worker's Compensation/Claims/Long & short-term Insurance
- ☐ Disability Claim
- ☐ Other _____

Information to be disclosed:

- ☐ All Records
- ☐ Laboratory/Pathology Results
- ☐ Radiology Results
- ☐ Other _____

This authorization is limited to the following dates of treatment:

FROM _____ TO _____

This authorization expires on: _____ (specify date or event)
**If the expiration date is left blank, the authorization will expire 60 days from the signature date

Preferred method of delivery:

- ☐ U.S. Mail: To this address: _____
  _____
- ☐ Pick up in person: (A government issued picture ID may be REQUIRED)
- ☐ Fax to Physicians Office: (Phone) _____ (Fax) _____

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Patient Name _____ Page 2 MRR

ADDITIONAL IMPORTANT INFORMATION
Information disclosed may include personal health information, such as your identity, diagnosis, and treatment.

- You have a right to revoke this authorization in writing at any time, except to the extent that information has been released in reliance upon this authorization;
- The information released in response to this authorization may be re-disclosed to other parties;
- Your treatment or payment for treatment cannot be conditioned on the signing of this authorization.

The following applies to records being released to the patient

I understand that, unless otherwise provided by law, the charge for this record will be $0.50 per page for each page copied ($0.25 per page after the first 50) plus a $10.00 handling fee. The office will contact you with the fee and at that time payment is to be made before records are copied.

Patient's Signature: _____

Date of Request: _____

IF THE REQUESTOR IS NOT THE SUBJECT OF THE RECORDS:
IF YOU ARE REQUESTING MEDICAL RECORDS FOR SOMEONE OTHER THAN YOURSELF, YOU MAY BE REQUIRED TO PROVIDE ADDITIONAL DOCUMENTATION TO SHOW YOU HAVE THE LEGAL RIGHT TO REQUEST THE RECORDS.

Legally Authorized Representative's name: _____

Representative's signature: _____

Relationship/Authority to request or sign on patient's behalf: _____

To Be Completed by Staff:

Fee: $ _____ Completed by: _____ Date: _____