Robert R. Hart, M.D
Anthony R. Vara, M.D.
Jonathan M. Mobley, M.D.

RELEASE OF INFORMATION AUTHORIZATION

(We Do Not Fax or Email Medical Records to Patients)

Patient Name: ____ DOB: ______/______/__________
(Please Print) Last First MI mm dd yyyy

Phone: ________________________ Email: ____

INFORMATION RELEASED **FROM**:
Facility Name: ______________________________ Provider Name: ____________________________
Address: ____
City: ________________________________ State: ______________ Zip: ______________
Phone: ______________________________ Fax: ______________________________

INFORMATION RELEASED **TO**:
Facility Name: ______________________________ Provider Name: ____________________________
Address: ____
City: ________________________________ State: ______________ Zip: ______________
Phone: ______________________________ Fax: ______________________________

The purpose of this request for medical records is: ____

INFORMATION TO BE DISCLOSED:

☐ Lab/Pathology Reports ☐ Hospital – operative reports or notes ☐ Radiology reports ☐ All Records

☐ Other (Date(s) of service requested) ____

I authorize Fair Oaks Urology to release the medical records requested above. I understand that, unless otherwise provided by law, the charge for this record will be $0.50 per page for the first 50 pages and each additional page will be $0.25, plus a $10.00 administrative fee. The office will contact you with the fee, at that time payment is due before records will be copied. Records can be picked up, faxed to another physician, or mailed USPS first class.

PLEASE ALLOW 5-7 BUSINESS DAYS FOR PROCESSING

Patient's Signature: ______________________________________ Date of Request: __________________

You have a right to revoke this authorization in writing at any time, except to the extent that information has been released.

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Fairfax, Virginia 22033
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Fax: (703) 207-0843
www.fairoaksurology.com

Administrative Fee (S9981) $ 10.00
$0.50 x_______ pages (S9982) = $ _____
$0.25 x_______ pages (S9982) = $_____
Total due from patient: $_____