

# FALLS CHURCH MEDICAL CENTER

## Authorization for Release of Medical Information

Release \_\_\_\_\_ TO \_\_\_\_\_ FROM

Falls Church Medical Center  
Medical Records Department  
6060 Arlington Boulevard  
Falls Church, Virginia 22044-2993  
703-533-2222

\_\_\_\_\_ TO \_\_\_\_\_ FROM \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize Falls Church Medical Center to release the specific information as indicated below including the diagnosis and records of treatment or examination rendered to the following designated individual(s).

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ All Medical Records including laboratory and X-ray reports  
\_\_\_\_\_ All Medical Records for the time period of \_\_\_\_\_  
\_\_\_\_\_ All Medical Records pertaining to the treatment by Dr. \_\_\_\_\_  
\_\_\_\_\_ Other specific records \_\_\_\_\_  
\_\_\_\_\_ X-Ray Films

\_\_\_\_\_ I will pickup these records \_\_\_\_\_ Mail records to address listed above

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Per Virginia Code a charge of \$10.00 for administrative preparation and fifty cents (\$0.50) per page for up to fifty pages and twenty-five (\$0.25) a page thereafter, plus all postage and shipping costs will be assessed for the duplication of records. The exact amount will be calculated and the patient informed of the amount prior to copies being made. I have read and agree to pay the charge for the administration, duplication and mailing/shipping of my medical records \_\_\_\_\_ (patient initials).

### BUSINESS OFFICE USE ONLY

Mailed: \_\_\_\_\_ Picked Up: \_\_\_\_\_ Physician: \_\_\_\_\_

Physician Authorization: \_\_\_\_\_ Fee: \_\_\_\_\_ Comments: \_\_\_\_\_