# RAPPAHANNOCK WOMEN'S HEALTH CENTER, P.C.

Medical Records Release Authorization

Patient: _____ DOB: _____

Address: _____

Phone: _____

Reason for Request: _____

If transferring, why? _____
_____
_____

Please have my physician send the following information: (mark all that apply)

___Complete Record
___Labs
___Ultrasound/Sonogram Results
___Progress Notes

I, _____, certify the above request is accurate and hereby authorize the release of these records.

| | | | |
|---|---|---|---|
| From: | _____ | To: | Rappahannock Women's Health Ctr. |
| Address: | _____ | | 1071 Care Way, Suite 101, Fredericksburg, VA 22401 |
| Phone: | _____ | | 540-374-3100 |
| Fax: | _____ | | 540-374-3102 |

*I agree to pay all fees associated with this release, based on the standard fees outlined below. There is a 7-10 business day waiting period. I understand that all sections of this form must be completed before it can be processed.*

_____ _____ _____
Signature of Patient Date Phone

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**Virginia law allows for copy charges consisting of the following:

| | | | |
|---|---|---|---|
| Processing Fee: | $20.00 ten pages or less | Date Copied: | _____ |
| | $35.00 for over ten pages | Date Released: | _____ |
| | $5.00 for one to two pages | Employee: | _____ |
| Additional Copy | $20.00 | | |
| Total Fee: | _____ | | |