Rappahannock Women's Health Center

1071 Care Way Suite 101
Fredericksburg, VA 22401
540-374-3100 Fax: 540-374-3102

Informed Authorization and Consent for the release of Medical Records

I hereby authorize Rappahannock Women's Health Center to:

( ) **RELEASE** ( ) **OBTAIN** Patient's Name: _____

Date of Birth: _____

Ph #_____

( ) **RELEASE TO:** ( ) **OBTAIN FROM:**

_____ _____

_____ _____

_____ _____

For the purpose of: _____

Please indicate what needs to be release:

( ) Entire Medical Record ( ) Mammography ( ) Lab Tests

( ) Operative Reports ( ) Pathology ( ) Discharge Summary

( ) Other: _____

I understand that the medical records may or may not contain information pertaining to alcohol or drug abuse counseling or testing, and/or HIV/STD testing. I do voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity (ies) as stated above. This authorization/consent will remain in effect for a period of ninety (90) days from the date stated below, unless revoked in writing by the person to which it pertains (his/her parent, legal guardian or legally authorized agent), o the Medical Records Department. These medical records are being disclosed under the provisions of the applicable Virginia State and Federal Law. Virginia law allows for copy charges consisting of the following listed below.

_____ _____

Patient Signature ***Date Signed***

There is a handling fee for release of medical records. A $20.00 administration fee, $0.50 per page for the first 50 pages and $0.25 for each additional page. All postage cost will be added to the cost of the medical records. Please allow 7-10 days for processing of all medical records. This fee includes sending the records from physician to physician or picking up in person.

Email completed form to RWHC-paperwork@outlook.com

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