COUNTRYSIDE
FAMILY PRACTICE

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RECORD RELEASE REQUEST

Date of request: _____
Patient Name (Last, First, MI, Suffix): _____
Address: _____
Phone Number: _____
Date of Birth: _____

REQUESTING RECORDS FROM:

Office Name: _____ Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

I HEREBY AUTHORIZE YOU TO RELEASE REQUESTED RECORDS TO:

Office Name: _____ Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____

Release to Patient: YES or NO
IS THIS REQUEST DUE TO A PERMANENT CHANGE OF DOCTOR? YES OR NO

Medical Records Fee (SET BY THE STATE OF VIRGINIA)
Handling Fee: $10.00 per request Copying: $0.50/ page up to 50 pages, $0.25/page thereafter
Disc. $25.00

Signature: _____ Date: _____

Please release the following medical record information: PLEASE CIRCLE OR ALL

___Office	___ECG Reports	___Operative Reports
___H&P	___Medication List	___Special Study Reports
___Specialist/Consult Notes	___Allergies List	___Immunization Report
___Lab-work	___Radiology Report	___Pathology Report