COUNTRYSIDE
FAMILY PRACTICE
NORRIS ROYSTON JR., MD • ROBERT HOUSKA, MD • KEVIN OLSON, MD
8255 EAST MAIN STREET • PO BOX 337 • MARSHALL, VA. 20116-0337
PHONE: 540.364.1581 • FAX 540.364.7314 • www.cfpdocs.com

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