513 W Broad St, Suite 100
Falls Church, Virginia 22046
Tel: 703-940-0000
Fax: 703-533-0321

Authorization for Release of Medical Records

Patient's Name:_____

Date of Birth: _____/_____/_____

Social Security Number: _____-_____-_____

Address: _____

_____

Telephone Number: (_____)_____-_____

Please release my medical records

FROM:
Name of provider, address, phone, and fax:

_____

_____

_____

_____

TO: Virginia Health Center, LLC
Dr. Philip J. O'Donnell
513 W. Broad St., Suite 100
Falls Church, VA 22046
Office# 703-940-0000 / Fax# 703-533-0321

Please release all medical records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays or MRI imaging and reports.

I hereby authorize the release of my medical records as provided above.

_____ _____
Patient's Signature Date