Virginia Health Center LLC

513 W Broad St, Suite 100
Falls Church, Virginia 22046
Tel: 703-940-0000
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Philip J. O'Donnell, MD
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Authorization for Release of Medical Records

Patient's Name:_____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Address: _____

_____

Telephone Number: (_____)_____-_____

Please release a copy of my medical records, including but not limited to, progress notes, operative notes and diagnostic tests for:

☐ Last 3 years ☐ Last 5 years ☐ All records

FROM:
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

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

_____

_____

_____

_____

NOTICE TO PATIENTS: As defined in Code of VA. Ann. 8.01-413, requests for copy or transfer of medical records will incur an administrative fee of $15 and a per page charge of 50 cents - for the first 50 pages, 25 cents per page thereafter. Postage charges are not included (if medical records are being mailed) and will be charged separately. Additionally, there will be a $15 surcharge for fast turnaround requests (when records are needed in 48 hours or less). Requests are processed in the order in which they are received. Please be aware that once your request has been received, it will be processed within 7-10 business days. Please note that radiology images (X-Rays, MRI's, CT Scans, Ultrasounds, Mammography, etc.), telemetry tapes or photos are not sent as part of your medical record. You must contact the office that provided the service to receive a copy of the documentation.

I hereby authorize the release of my medical records as provided above. My signature acknowledges that I have reviewed and agreed with the above information.

_____ _____

Patient's Signature Date

VHC 03/21