ARLINGTON MEDICAL ASSOCIATES, PLLC

Authorization for Release of Medical Information

Release ☐ TO ☐ FROM Arlington Medical Associates, PLLC
2800 S. Shirlington Road Suite 410
Arlington, VA 22206
Tel.: 703-533-2222

☐ TO ☐ FROM _____

_____

_____

I hereby authorize Arlington Medical Associates, PLLC to release or receive specific information as indicated below, including the diagnosis, records of treatment and examinations rendered to the following designated individual(s):

Name: _____ DOB: _____

Name: _____ DOB: _____

Reason for request: ☐ Continuation of Medical Care ☐ Legal ☐ Personal

☐ All medical records including information regarding any treatment or evaluation of psychiatric conditions and/or HIV/AIDS.

☐ All medical records for the time period of _____

☐ All medical records pertaining to the treatment by Dr. _____

☐ Other specific records _____

☐ I will pick up these records ☐ Fax records to 703-533-3421

☐ Mail records to the address listed above.

Date: _____ Signed: _____

Relationship: _____ Phone: _____

In accordance with 8.01-413 of the Code of Virginia, a charge of $10 for administrative preparation and $ 0.50 (fifty cents) per page for up to 50 pages and $ 0.25 (25 cents) a page thereafter, plus all postage and shipping costs will be assessed for the duplication of records. The exact amount will be calculated and the patient informed of the amount prior to copies being made.

I have read and agree to pay the charge for the administration, duplication and mailing/shipping of my medical records. _____ (Patient initials)

BUSINESS OFFICE USE ONLY

Mailed _____ Picked up _____ Physician_____

Physician Authorization _____ Fee _____