MEDICAL RECORDS REQUEST FORM

Records From:

Please fill out completely. Incomplete forms cannot be processed.

Doctor or Office Name	Phone	Fax	
Address	City	State	Zip

Patient Name	Birth Date

Description of health information desired:

- ☐ **Complete Records**
- ☐ **Immunization Records**
- ☐ **Ultrasound**
- ☐ **Imaging**
- ☐ **EKG**
- ☐ **Labs**
- ☐ **Other: _____**

This authorization shall remain in effect for one year from the date of signature. You may cancel this authorization at any time by presenting a written request to Rocky Run Family Medicine. Your cancellation will not affect information that was released prior to receipt of your written request. Once the information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

I hereby authorize and request you to release the following records in your possession to:

Rocky Run Family Medicine ☐ **Go Green! Please check here to request records be FAXED to our office.**

5645 Stone Rd, Centreville, VA, 20120 PHONE: 703-266-2442 FAX: 703-266-7158

Patient, Parent/Guardian Signature	Date

Patient Name	Cell Phone	Home Phone	
Street Address	City	State	Zip Code