I hereby authorize the release of my medical records to:

Tepeyac OB/GYN

4001 Fair Ridge Drive, Ste. 304

Fairfax, VA 22033

Phone: 703-273-9440 Fax: 703-273-9445

□ All Records □ X-Ray/Sonogram Reports □ Prenatal Reports □ Discharge Summary

□ Operative Reports □ Lab Reports □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request to Provider (Choose One): □ Fax □ Mail

Patient Information:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | | | | Date of Birth: | |
| Address: | | City: | State: | | Zip Code: |
| Phone: | Signature of Patient or Legal Guardian: | | | | |

Provider Information:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Requesting Records From: | | | | |
| Address: | City: | | State: | Zip Code: |
| Phone: | | Fax: | | |

To avoid delay in processing your request, please complete this form with the correct information. Call your prior doctor’s office and obtain their address and fax number if you do not know it.

**TO THE PROVIDER:** Protected Health Care Information is personal and sensitive information related to a person’s healthcare. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.