



AUTHORIZATION TO REQUEST / RELEASE MEDICAL RECORDS

4001 Fair Ridge Drive, Suite 304, Fairfax, VA 22033 | 703-273-9440 | Fax 703-273-9445

* All items marked with an asterisk are required.

A	PATIENT INFORMATION
* Patient Name: _____	* Date of Birth: ____/____/____
Contact Email: _____	* Contact Phone: _____
* Address: _____ City: _____ State: _____ ZIP: _____	
B	RECORDS TO / FROM TEPEYAC
* I authorize (check one): ☐ TEPEYAC OB/GYN to RELEASE the records indicated below TO: ☐ The person/provider/organization below to RELEASE the records indicated below TO TEPEYAC OB/GYN:	
* Name: _____ Address: _____ Phone: _____ Fax: _____ Email: _____	
C	INFORMATION TO BE RELEASED
* Dates of Service: From _____ To _____ ☐ All dates	
* Select records: ☐ All health records ☐ Other: _____	
D PURPOSE	E PREFERRED DELIVERY METHOD
☐ Continuing care ☐ Transferring care / leaving practice ☐ Personal use ☐ Insurance/Disability ☐ Legal ☐ Other: _____	☐ Patient Portal ☐ Secure Email ☐ Fax ☐ CD / Flash Drive ☐ Printed Pick-up* ☐ Other: _____ *Electronic copies are provided at no charge. Printed paper copies requested by the patient may be subject to a \$0.25 per-page copying fee, as permitted by applicable federal and Virginia law.
F	AUTHORIZATION & SIGNATURE
I understand that: • I may revoke this authorization in writing at any time. Revocation will not affect records already disclosed in reliance on this authorization. • Treatment or payment will not generally be conditioned on signing this authorization, except as permitted by law. • Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected to the same extent by applicable privacy laws. • The selected records may contain sensitive information unless a separate authorization is required by law. • Printed copies requested by the patient may be subject to a \$0.25 per-page copying fee, as permitted by applicable federal and Virginia law. Electronic copies are provided at no charge. • A copy of this authorization and a notation of disclosures will be maintained with my health record. • This authorization expires upon completion of this request, or six months from the date signed, whichever occurs first.	
* Signature of Patient / Authorized Representative: _____ * Date: _____	
* Print Name: _____ ☐ Self Relationship/Authority: _____	