The Physicians & Midwives Collaborative Practice

5901 Kingstowne Village Parkway, Suite 200
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Request for Medical Records

I, _____, hereby request and authorize the Physicians & Midwives Practice to release my medical records to:

[ ] Myself/Patient [ ] Doctor/Practice [ ] Other

Please Indicate Name/Practice & address to whom records will be sent to:

_____

_____

_____

My Full Name: _____
Date of Birth: _____
Address: _____
Telephone #: _____
Social Security No.: _____

[ ] I would like ALL my medical records.
[ ] I would like a specific office visit, lab report, or other type of document.
Please Indicate what specific document and date: _____

I am requesting my records because: [ ] I am Moving [ ] I am transferring practices
[ ] Another physician requests it.
[ ] Other Reason: _____

I need my medical records by: _____**

[ ] I would like to pick up my records in person.
[ ] I would like my records faxed to: _____
[ ] I would prefer that copies of my records be mailed to the above physician's office.

I understand by signing this document that I am allowing Physician & Midwives to release the stated documents I have requested. I also understand that I am subject to any fees associated with the processing of these records. (Usual fee = $25.00) I understand that this fee is due prior to the records being released and will either call with credit card information or mail a check for $25.00.

My Signature: _____ **Date:** _____
(Name printed: _____**)**

****Note: Processing medical records can take up to 15 days from the requested date****