

MEDICAL RECORDS RELEASE REQUEST

Patient Name: _____ **DOB:** _____

I hereby authorize the following:

Release medical information on file with:

Send to: ***Doc At Your Door, PLC, 332 W Lee Hwy, #251, Warrenton, VA 20186***
(Fax: 540-351-8650)

Please send:

All records

The following: _____

Do not send: _____

Release any existing medical information on file with *Doc At Your Door, PLC* to:

Please send:

All records

The following: _____

Do not send: _____

- Please allow 72 business hours for processing all requests.
- I understand processing fees may apply, pursuant to limits established by the Virginia Board of Medicine.
- I understand that I may revoke any or all of this authorization at any time.

Patient Signature (or that of legal representative)

Date

Legal Representative Name (please print)

Relationship