DOC AT YOUR DOOR
Physician House Calls and More

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: 1-833-362-8800)

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 Phone or E-mail