



480 W Jubal Early Drive
Suite 300
Winchester, VA 22601

540-431-2330 Fax 540-409-5977

Authorization for Release of Medical Records

Print Patient Name Date of Birth Request Date

Patient Address

Please release medical records pertaining to _____

Including diagnosis, treatment and examination **FROM** the facility below:

I, _____, am requesting these medical records be released **TO**

Patient signature

The facility below:

Women First
480 W Jubal Early Dr, Suite 300
Winchester, VA 22601