



## Medical Records Request

*I hereby request that the following medical records:*

All Records: \_\_\_\_\_

Other, please specify: \_\_\_\_\_

*be released from:*

Dr. \_\_\_\_\_

Address: \_\_\_\_\_

*and sent to the following physician*

Dr. \_\_\_\_\_

*at the Virginia Women's Center location checked below:*

St. Mary's MOB, South  
5875 Bremono Road, Suite 400  
Richmond, VA 23226  
Attn: Medical Records  
Fax # 804-282-2601  
Phone # 804-288-4084

Henrico Doctors' Professional Bldg  
7611 Forest Avenue, Suite 200  
Richmond, VA 23229  
Attn: Medical Records  
Fax # 804-288-3567  
Phone # 804-288-4084

Memorial Regional Medical Ctr. MOB II  
8266 Atlee Rd, #330  
Mechanicsville, VA 23116  
Attn: Medical Records  
Fax # 804-559-2046  
Phone # 804-288-4084

Kilmarnock Office  
102 DMV Drive  
Kilmarnock, VA 22482  
Attn: Medical Records  
Fax # 804-433-2392  
Phone # 804-288-4084

John Rolfe Commons  
2240 John Rolfe Parkway  
Richmond, VA 23233  
Attn: Medical Records  
Fax # 804-545-9548  
Phone # 804-288-4084

I understand that this authorization will be valid for 6 months.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Virginia Women's Center has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to Virginia Women's Center at the address checked above.

Patient's Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

Date \_\_\_\_\_ Date Last Seen in Office \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for Transfer \_\_\_\_\_

*Office Use Only*

OB

GYN