

Jefferson Obstetrics & Gynecology, Ltd.

600 Peter Jefferson Parkway, Suite 290

Charlottesville, VA 22911

434-977-4488

434-977-6103 Fax

www.jeffersonobgyn.net

REQUEST FOR MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone Number(s) _____

Name, address, telephone and fax number of physician

A. Where the records are being requested from **OR**

B. Where you are requesting that your records be sent. **CIRCLE A OR B**

Physician's Name _____

Address _____ City _____ State _____ Zip _____

Telephone Number: _____ Fax Number: _____

_____ The patient is hereby requesting any and all information related to past and present medical conditions, histories, diagnoses and treatment.

_____ The medical records concerning the period from _____ to _____ are requested.

Purpose for release: _____

This authorization expires: _____

I understand that the medical records to be released may contain information related to HIV, AIDS, sexually transmitted diseases, alcohol/drug use or mental health services and I hereby authorize the release of this information.

Patient's Signature _____

Date of signature _____ Time of signature _____

Authorized Signature _____

Witness _____

Date _____

Please promptly release these records for the benefit of the patient's continued care. If you are unable to release them immediately, please contact medical records in our office immediately at 434-977-4488 option 4.

This request is valid for a period of 90 days from the request.