



MEDICAL RECORDS RELEASE AUTHORIZATION

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Reason for Request: \_\_\_\_\_

If transferring, Why? \_\_\_\_\_  
\_\_\_\_\_

Please have my physician send the following information: (mark all that apply)

- Complete Record
- Labs
- Ultrasound/Sonogram Results
- Progress Notes

I, \_\_\_\_\_, certify the above request is accurate and hereby authorize the release of these records.

From: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

To: **Southpointe OBGYN**

Address: **4710 Spotsylvania Pkwy Ste 205, Fredericksburg, VA 22407**

Phone: **540.710.2324**

Fax: **540.710.2381**

\*I agree to pay all fees associated with this release, based on the standard fees outlined below.  
I understand that all sections of this form must be completed before it can be processed.\*

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHONE

\*\*Virginia law allows for copy charges consisting of the following: \$10 administrative fee  
PLUS \$0.50 per page for the first 50 pages and \$0.25 per page thereafter.\*\*

Administration Fee: \$10.00

\$0.50 per page up to 50 pages: \_\_\_\_\_

\$0.25 per page thereafter: \_\_\_\_\_

**Total Fees:** \_\_\_\_\_

Date Copied: \_\_\_\_\_

Date Released: \_\_\_\_\_

Employee: \_\_\_\_\_