3299 Woodburn Rd, #230, Annandale, VA 22003
Phone: 703 205-2626 Fax: 703 205-2630

REQUEST TO RELEASE OUTPATIENT CENTER MEDICAL RECORDS

I, _____,
request and authorize the following provider:
(Patient*, Parent, Legal Guardian)

(Please place a checkmark by your provider)

_____ Hymes, Robert MD
_____ Malekzadeh, Stephen MD
_____ Schulman, Jeff E. MD
_____ Schwartzbach, Cary MD
_____ Levine, Matthew MD
_____ Dziadosz, Daniel MD

to release medical records for the patient:

Patient legal name: _____

DOB of Patient: _____

to the individual listed below: (Please print name, address and phone/fax)

_____
Physician, Parent, Legal Guardian, Patient (Patient must be of legal age.)

_____
Mailing Address

_____
Phone/Fax Number

Authorized by: _____
Print
name of Patient*, Parent, Legal Guardian

_____
Signature
of Patient*, Parent , Legal Guardian

Date_____