



7611 Little River Turnpike, Suite 101-E, Annandale, VA 22003
Phone: (703) 256-2307 Fax: (703) 256-3230

2020-A Opitz Boulevard, Woodbridge, VA 22191
Phone: (703) 494-9173 Fax: (703) 494-8109

10600 Crestwood Drive, Manassas, VA 20109
Phone: (703) 368-7874 Fax: (703) 368-0817

Request for Medical/Dental Records

Name: _____ Date: _____

Your Address: _____

City: _____ State: _____ Zip Code: _____

The purpose of this letter is to request copies of my medical records as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations.

I was treated in your Annandale/ Woodbridge (circle one) office between _____
I request copies of the following related to my treatment:

X-Ray* _____

Medical History* _____

Physician Notes* _____

Test Results* _____

Referrals* _____

All Available Records* _____

*I understand you may charge a "reasonable" fee for copying the records, and/or administrative fees for time spent locating the records. Please mail the requested records to me at the above address [If you request that the records be mailed, you may also be charged for postage].

I look forward to receiving the above records within 30 days as specified under HIPAA, unless other arrangement with the office has been made. If my request cannot be honored within 30 days, please inform me of this by letter as well as the date I might expect to receive my records*.

Signature _____

Print Name: _____

Office Use Only

Received by: _____

Date completed: _____

Reason: _____