DOMINION
PLASTIC SURGERY

2755 Hartland Road, Ste. 300
Falls Church, VA 22043
Phone: 703-544-8971 Fax: 703-562-6994

Medical Record Release

_____ _____
Patient's Full Name *Date of Birth*

_____ _____
Street Address *Social Security Number*

_____ _____
City, State, Zip Code *Patient's Telephone Number*

_____ _____
Parent/Guardian if Patient is <18 yrs. *Date of Service(s)*

Information to be Released/Disclosed:

- ☐ Operative Notes
- ☐ Office Notes
- ☐ Photographs
- ☐ Prescriptions and/or Physician Orders
- ☐ Hand and/or Occupational Therapy Notes
- ☐ HCFA Forms (ICD-10 codes)
- ☐ Itemized Billing Statement

I hereby authorize Dominion Plastic Surgery to disclose the following information to:

_____ **Phone #:** _____
Name of person or entity to receive information
(Fill in completely even if records are being returned to you) **Fax #:** _____

_____
Street Address *City* *State* *Zip Code*

Purpose of disclosure:

- ☐ Appointment with another physician (Specify physician's name): _____
  Referred by our office? ☐Yes ☐No
- ☐ Legal Investigation
- ☐ Insurance
- ☐ Disability Determination
- ☐ Workers Compensation
- ☐ Personal
- ☐ Relocation/Moving
- ☐ Other (Please specify): _____

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA Privacy Regulations, the information described above may be re-disclosed and no longer protected by these regulations. I understand and accept full responsibility for the condition and location of my medical records and release Dominion Plastic Surgery of any liability from loss or damage of these records. Dominion Plastic Surgery is released from any and all liability that may arise from the release of my health records. I understand proof of identity will be required of the person picking up my medical records.

I understand that written notification is necessary to cancel this authorization and can be addressed to our office, at the address listed at the top of this form. I am aware that my cancellation will not be effective to disclosures already made in reference to this authorization. The authorization is valid for 12 months from the date of signature. Federal and state law permit a fee to be charged for copying of patient records. An invoice will be sent to you either by fax or mail after the request has be filed.

PREPAYMENT IS REQUIRED PRIOR TO RELEASE OF RECORDS. ALLOW 7-10 DAYS AFTER PAYMENT.

_____ _____
Signature of Individual, Guardian, or Personal Representative of Patient's Estate *Date*