

**THE ADLER CENTER FOR WOMEN'S HEALTH**

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385 Garrisonville Road Suite 204 Stafford, VA 22554 Ph. (540) 659-0928 Fax (540) 659-3019

**REQUEST FOR RELEASE OF MEDICAL RECORDS**

PATIENT'S NAME:(Please print)\_\_\_\_\_ Today's Date:\_\_\_\_\_

DATE OF BIRTH:\_\_\_\_\_ SSN:\_\_\_\_\_

PATIENT'S SIGNATURE\_\_\_\_\_ WITNESS:\_\_\_\_\_

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS Virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

REASON FOR REQUEST: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize **The Adler Center for Women's Health** to release copies of my medical records to the following address:

Name:\_\_\_\_\_

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

Phone Number:\_\_\_\_\_ Fax Number:\_\_\_\_\_

THE RECORDS IN YOUR POSSESSION, CONCERNING MY MEDICAL CARE FROM  
\_\_\_\_\_ TO\_\_\_\_\_.

\_\_\_\_\_ Copy of all office and/or  
hospital records including  
results of lab tests

\_\_\_\_\_ Pathology Reports

\_\_\_\_\_ Operative Reports

\_\_\_\_\_ Sonogram and/or Mammogram Reports

\_\_\_\_\_ Other (Please Specify):\_\_\_\_\_

**Note:** There may be a charge for release of medical records. Our fee for this service is based on Virginia's Health Privacy statute [§32.1-127.1:03(J)] which states "If an individual requests a copy of his health record from a healthcare entity, the healthcare entity may impose a reasonable cost-based fee, which shall include only the cost of the supplies for and labor of copying the requested information [and] postage when the individual requests that such information be mailed."