Culpeper Medical Clinic
Walk-in & Primary Care

451 James Madison Hwy, #104
Culpeper, VA 22701
Phone: (540) 727-8880
Fax: (540) 727-8882

Medical Records Request Form

TO: (Name of Provider/ Facility): _____
Street address: _____
City, State and Zip: _____
Phone: _____ Fax: _____

RE: Patient Name: _____ DOB: _____

I, the patient, or legally authorized representative, authorize and request the disclosure of all protected information be sent as soon as possible to the following medical office:

Culpeper Medical Walk-in Clinic
451 James Madison HWY, Suite #104
Culpeper, VA 22701
Phone: (540) 727-8880 - Fax: (540) 727-8882

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ All medical records (Specify date range if applicable: _____)
- ☐ All laboratory, histology, cytology, pathology, immunohistochemistry records
- ☐ All radiology records and films including CT scan, MRI, MRA, EMG, etc.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This protected health information is disclosed for the purpose of review and evaluation in connection with continuity of medical care. I understand the following: a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient (if applicable)