Medical Records Release Form

As a patient of Ashburn Family Healthcare, you have the right to access or obtain a copy of your medical records. **Please understand that original records are a property of Ashburn Family Healthcare.** Please complete this form in its entirety and sign before submitting your request:

Name(s) of Patient(s): DOB:

_____ _____
_____ _____
_____ _____

Current Home Address and Phone number of Patient/Legal Guardian:

_____
_____

By signing this form, I authorize Ashburn Family Healthcare to release protected health information about me/ my child (if patient is less than 18 yrs of age), by releasing a copy of medical records to:

_____
_____

The purpose of this disclosure is: _____

I authorize the use and disclosure of information in my medical record relating to:
(Initial in space provided) _____ Psychiatric/Mental Health _____ Substance Abuse
_____ STDs/HIV/AIDS _____ Pregnancy/Contraception

Release of records will be processed within TEN business days of receipt of request. Charges associated with copying the medical records (VA Code 8.01-413B) are as follows:

- ☐ Request for 1 or 2 pages (e.g. last lab or radiology results, immunization record etc): No Charge
- ☐ Request for complete/partial records:
  - Processing fee: $10 per patient and
  - Copying fee: Pages 1– 50: $0.50 per page; remaining pages: $0.25 per page

Charges will be calculated and communicated to you after reviewing your request. Payment is expected prior to release of any records. Payment options include cash or credit card only.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so by presenting my written revocation to Ashburn Family Healthcare. The revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Patient/Legal Representative: _____ Relationship to Patient: _____ Date: _____

(For Office Use Only)

Patient 1	Patient 2	Patient 3
Total no of pages: _____	Total no of pages: _____	Total no of pages: _____
@ 0.50 x _____=_____	@ 0.50 x _____=_____	@ 0.50 x _____=_____
@ 0.25 x _____=_____	@ 0.25 x _____=_____	@ 0.25 x _____=_____
Processing Fee: _$10.00	Processing Fee: _$10.00	Processing Fee: _$10.00
TOTAL COST: _____	TOTAL COST: _____	TOTAL COST: _____

Provider authorizes release of records: Y/ N Provider's initials _____ Date_____

Date Patient advised of Charges: _____ Initials: _____
Date Payment received: _____ Initials: _____
Date records released: _____ Initials: _____