



Prince William OBGYN
MEDICAL RECORD RELEASE FORM

I hereby authorize Prince William OB/GYN Associates, Ltd. to release:
any information including diagnosis, records and test results of any treatment or examination rendered OR
limited to during the period from to

TO: DATE:
Fax # (10 pages or less)

Print Patient's Name Date of Birth

Patient's Address Social Security Number

Telephone #

This authorization will expire six months from the date of signature.
I understand that once my medical records have been released that additional disclosure may occur and personal
health information may no longer be protected by the Privacy Rules defined by HIPAA.
Treatment may not be withheld by Prince William OB/GYN Associates, Ltd. based on my refusal to sign this form.

Patient's Signature

In accordance with state law (SB 281 and HB 1110) there will be a handling and retrieval charge of \$10.00, a charge
of \$ 0.50 per page for the first 50 pages and \$ 0.25 per page for every page thereafter, plus postage. Copying charges
will be waived for records going directly to another physician. Copies of physician records shall be furnished
within fifteen (15) days of this request.

Please indicate the reason for record transfer:

Change of doctor because

Moved

Change of Insurance to:

Dissatisfaction with service. If so, please comment:

Other, please explain:

8640 Sudley Road, Suite 303
Manassas, VA 20110
703-361-7778
Fax 703-361-1811

7508 Gardner Park Drive
Gainesville, VA 20155
571-261-2236
Fax 703-361-1811