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Medical Records Release Form

Please release medical records for:

Patient Name:_____DOB_____SSN_____

- ○ Please send the entire medical record
- ○ _____ (specify if only part of the record)

Please check for reason for transfer:

1. Moving _____
2. Insurance Change _____
3. Dissatisfaction _____
4. Other _____

If you or a family member is leaving the practice, please consider disclosing the reason.

- ○ Quality of medical care
- ○ Responsiveness to needs by physicians
- ○ Responsiveness to needs by staff
- ○ Ease of contacting the practice by phone
- ○ Responsiveness of billing or insurance staff
- ○ Would the patient return to the practice for care? YES_____ NO _____

Best phone number or email to reach the patient or guardian _____

Please mail to address:

_____

_____

_____

Signature of Patient/Guardian _____ Date _____

PLEASE NOTE: PURSUANT TO PARAGRAPHS 8.01-413 OF THE VIRGINIA CODE, THERE IS A FEE FOR RETRIEVAL OF ATTENDING PHYSICIAN RECORDS AS FOLLOWS:

$15.00 HANDLING FEE (SEARCH, COPYING, POSTAGE, ETC.)

CHECKS ARE MADE PAYABLE TO DIGESTIVE DISEASE PHYSICIANS.
CREDIT CARDS ARE ALSO ACCEPTED.

STANDARD PROCESSING TIME IS 5-7 BUSINESS DAYS AFTER RECEIPT OF PAYMENT
****PLEASE NOTE THAT MEDICAL RECORDS ARE PROCESSED ON MONDAYS****