



REQUEST FOR MEDICAL RECORDS AUTHORIZATION

Patient's Name: \_\_\_\_\_  
First Name MI Last Name

Date of Birth: \_\_\_\_\_ Last 4-digits of Social Security Number: \_\_\_\_\_

Release Medical Records:

TO  FROM  
Physician \_\_\_\_\_  
Facility \_\_\_\_\_  
Address \_\_\_\_\_  
City, State Zip \_\_\_\_\_  
Fax Number \_\_\_\_\_  
Phone Number \_\_\_\_\_

TO  FROM  
Virginia Urology \*  
Medical Records Dept  
9105 Stony Point Dr.  
Richmond, VA 23235  
Phone: (804) 272-1438  
Fax: (804) 521-1061

Information requested:  All Medical Records  Laboratory Reports  Radiology  
Other: \_\_\_\_\_

I authorize the release of the above requested records.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Signature of Authorized Representative of Patient Date  
 Power of Attorney  Guardian  Other \_\_\_\_\_

\* I understand that I have the right to access my medical records in accordance with the law and the policies of Virginia Urology. I understand that Virginia Urology may charge me \$10.00 for copies of my medical records. I understand that Virginia Urology has the right to deny me access to my records in certain circumstances in accordance with the law. If Virginia Urology denies me access to my medical information, I understand it will provide me with the reasons for the denial in writing and describe whether I have the right to have a review of the denial performed by a licensed health care professional.

Please note that information disclosed pursuant to this request is no longer under the control of Virginia Urology and may no longer be protected by federal or state law.

If you have any questions, please contact Virginia Urology Medical Records (804) 272-1438