Medical Records Request

Patient's Name: ____

Address:

____

Date of Birth:______________________________ Phone #____________________________________

Within the Guidelines of the Code of the Commonwealth of Virginia, I request that a copy of my medical record or other medical information be provided as listed below. I understand that the practice has up to 30 days to fulfill my request.

______ I, the above mentioned patient, will pick up the requested records at MVIMP.

______ My authorized representative, _______________________________________ will pick up the records on my behalf.

_______ FAX a copy of records to: ____

FAX #: ____

For these services, I agree to pay the amounts defined by the VA Code of $.50/page for the first 50 pages, and $.25/page for pages after page 50, plus any cost for mailing. These fees will be paid before the records are released from MVIMP.

*I understand that no Protected Health Information (PHI) may be transferred via email.

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Patient Signature Date