RECORD RELEASE

Quality Internal Medicine, PLLC
1860 Town Center Drive
Suite 255
Reston, VA 20190
Phone: 703 707-0607
Fax: 703 707-0949

Patient Name:_____
Patient Address:_____
_____
Patient DOB: _____
Patient SS#: _____

_____I hereby request my records be released to:

_____ I request my records be sent to Quality Internal Medicine from:

Entity Name: _____
Address: _____
_____

Please send the following specific information:

_____Hospital/Operative Records

_____Laboratory Reports

_____Radiologic Reports

_____Office Notes

_____All components of my record including the above

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released and release Quality Internal Medicine and the above named entity and its staffs from all legal responsibility that may arise from the act thereby authorized. This authorization may be amended in any way by crossing out or adding and initialing changes. This authorization may be revoked by not retroactive to the release of the information made in good faith.

Signature:_____ (patient, legal guardian)

Witness: _____

Date:_____

This authorization expires ninety (90) days from the date of this signature.