



Request for Release of Medical Records

Millennium Medical Care Reston
1800 Town Center Dr, #220
Reston, VA 20190
703-440-7000
703-440-7999 (Fax)

Patient's Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Email Address: _____

I here by authorize records FROM:

To be released TO:

Name: _____

Name: _____

Address: _____

Address: _____

City/State/Zip: _____

City/State/Zip: _____

Phone #: _____ Fax#: _____

Phone #: _____ Fax#: _____

For the purpose of:

Date Range: _____ to _____

- | | | | |
|---|-------------------------------------|--|---|
| <input type="checkbox"/> Litigation | <input type="checkbox"/> Disability | <input type="checkbox"/> Physician Office Notes | <input type="checkbox"/> Cardiology/EKG Reports |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Work Comp | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Lab/Path Reports |
| <input type="checkbox"/> Self/Personal Copy | <input type="checkbox"/> Other | <input type="checkbox"/> Operative/Procedure Reports | <input type="checkbox"/> Radiology/Xray/MRI Reports |
| <input type="checkbox"/> Transfer or Continuity of Care | | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Minimum Necessary |

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. If I do so, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature _____ Today's Date: _____

Print Name _____