Request Medical Records from other Medical Facilities

To: Company Name/ Doctor's Name _____
Phone Number: _____
Fax Number: _____

I hereby request that you release medical records for the following patient(s):

PLEASE PRINT FULL NAME

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

To:

Hoadly Medical Care	**Hillendale Medical Care**	**Herndon Medical Care**	**Caremed Family Practice**	**Millennium Medical Care Stone Springs**
6356 Hoadly Rd Manassas, VA 20112	13168 Centerpointe Way Suite #101 Woodbridge, VA 22193	1043 Sterling Rd Suite #104 Herndon, VA 20171	11213 Lee Hwy Suite H Fairfax, VA 22030	24430 Stone Springs Blvd Suite 200 Sterling, VA 20166
703-590-5999 703-590-5399 (Fax)	703-730-2000 703-730-6767 (Fax)	703-689-0111 703-689-0077 (Fax)	703-832-8023 703-776-9499 (Fax)	703-665-2027 703-665-2195 (Fax)

Notes: _____

Patient or Patient's Parent/Guardian Signature: _____

Print Name: _____ Date: _____

********** *For internal purpose only* **********

First Attempt: _____
Second Attempt: _____
Third Attempt: _____