Alexandria Location
4660 Kenmore Ave, Suite 1120
Alexandria, VA 22304

tel: 703-680-2111
fax: 703-878-3939

Woodbridge Location
2296 Opitz Blvd, Suite 350
Woodbridge, VA 22191

Authorization for Release of Information

Patient Name: ____
(Please Print) First Middle Last

Birth Date:______________ Social Security #:________________ Phone: ___________________________

Information released **FROM**:

Clinic Name:____

Provider Name:____

Address:____

City:______________________State:________________Zip:________________

Phone:__________________________Fax:______________________________

Information released **TO**:

Clinic Name:____

Provider Name:____

Address:____

City:______________________State:________________Zip:________________

Phone:__________________________Fax:______________________________

Purpose of disclosure:____

Information to be disclosed:

☐ Clinic visit notes, consultations/follow-up visit
☐ Hospital-operative reports, consultations, ER visits and discharge summaries
☐ Other (Date(s) of service requested):__________________________________
☐ X-ray and lab reports
☐ All of the above

I authorize release of my medical records from Potomac Urology in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material at a cost of $10 administration fee, $0.50 per page for the first 50 pages and $0.25 per page after 50 pages. These charges are in accordance with the VA CODE A01-4V13. I understand that once information is released under this authorization, the clinic, employees and physicians cannot prevent disclosure of information. Information not originally generated by Potomac urology Center will not be released. Such information must be obtained from the original source.

******PLEASE ALLOW 7-10 BUSINESS DAYS FOR PROCESSING******

Signature:____________________________________ Date:__________________

Relationship/reason if other than patient:______________________________

(I understand that I may revoke this consent at any time and this authorization is valid for one year unless otherwise noted.)

Office use: $10.00 administration fee

$0.50 x _____ pages=$_____

$0.25 x _____ pages=$_____

TOTAL due from patient: $______