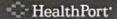
## Vienna Family Medicine 115 Park Street SE, Suite 300 Vienna, VA 22180 (703) 255-9100

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please note: An invoice for payment from HealthPort will be sent to you for your records. Please contact HealthPort Customer Service at (800) 367-1500 with any questions.

Print patient's full name			DOB (MM/DD/YY)					
Street Address			Primary Phone Number - Home/Mobile/Work					
City, State, Zip Code			Secondary Phone Num	ber – Home/Mobile/Work				
At the request of the individual, I	atient's Name	, do hereby a	authorize Fairfax Family P	ractice Centers to release:				
Dates of								
IEALTHPORT:Discharge Summar	y Hi	story & Physical	Pathology Reports	ALL RECORDS				
ECG/EEG/Cardia	c Cath Op	perative Notes	Progress Notes					
Emergency Repor	ts La	boratory Reports	Radiology Reports					
CHECK HERE for HEALTHPORT e-Delivery	Name of C	ompany/Agent/Facili	ty/Person					
Additional Form required	Street Add	ress						
	City, State,	Zip Code						
PURPOSE OF DISCLOSURE:								
Referral to Specialist	Insurance	Persona	l Leaving	g Practice				
Legal Investigation	_ Workers Com	p Continu	ing Care Disabili	ity Determination				
I hereby authorize disclosure of health information may cancel this request with written notification used or disclosed may be subject to re-disclosure I understand that the medical provider to who this	but that will not affect by the person or class	et any information released as of persons or facility rec	d prior to notification of cancellat serving it and would then no longer	er be protected by federal regulations.				

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. HealthPort has been contracted to provide this service and will bill you directly. VA State rates apply. Pages 1-50 \$ 0.50/page. Pages 51+ are \$0.25 each plus the cost of first class postage.



## Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

pies.																			
Requestor Name				Firs	t									]	Last				
Street	treet Street ddress City							Suite / Apt #											
Address								State / Zip Code											
			F	Ema	il A	ddr	ess	for	Rec	ord	Del	ive	y						
Patient Name	First		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	N	Med	ical	Red	corc		equ MI	este	ed			Last				
Date of Birth																			
Date of Service	From						9		- ,	Го									

Please provide me with the medical records described above through the HealthPort eDelivery online service.

I understand and agree that:

- > I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on HealthPort's eDelivery website.
- > I will receive an email from HealthPort.com containing instructions for accessing my records.
- > If I do not retrieve my records within 30 days, they will be deleted.
- > There will be a fee for collecting my records. If so, an invoice will be included with the records.

Signature	Date	