Medical Records Release

Please release all medical records for my Child/Children.

Name _____ D.O.B_____

Name _____ D.O.B_____

Name _____ D.O.B_____

Name _____ D.O.B_____

Name _____ D.O.B_____

Name _____ D.O.B_____

Please check reason for transfer of records:

1) Moving_____ 2) Insurance Change_____ 3) Dissatisfaction_____

(Please write any reasons or comments on back of sheet.)

Please **EMAIL** to the following address: _____

If you would like you records mailed, an additional postage fee of $5 will be added.

Please **MAIL** to the following address: _____

Signature of Parent/Guardian: _____Date: _____

Phone Number: _____

PLEASE FAX SIGNED FORM TO:

Lansdowne: (703) 723-8278 Purcellville: (540) 338-9482 Stone Springs: (703) 665-2376

There is a $10 charge per child for all records copied for current patients. Locating off-site archived charts will incur a $30 charge per child. Postage fee for mailed records is $5.

Medical records will be released/mailed upon receipt of payment

PLEASE REMIT ALL PAYMENTS TO THE ATTENTION OF:

Loudoun Pediatric Associates

19500 Sandridge Way, Suite 110 Leesburg, VA 20176