MILLENNIUM MEDICAL CARE
Your Health is Your Wealth

Request for Release of Medical Records

Hoadly Medical Care
6356 Hoadly Rd
Manassas, VA 20112
703-590-5999
703-590-5399 (Fax)

Hillendale Medical Care
13168 Centerpointe Way Ste# 101
Woodbridge, VA 22193
703-730-2000
703-730-6767 (Fax)

Herndon Medical Care
1043 Sterling Rd
Suite 104
Herndon, VA 20170
703-689-0111
703-689-0077 (Fax)

CareMed Family Practice
11213 Lee Hwy
Suite H
Fairfax, VA 22030
703-832-8023
703-776-9499 (Fax)

Stone Springs Medical Care
24430 Stones Springs Blvd, Ste #200
Sterling, VA 20166
703-665-2027
703-665-2195 (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 _____	
____Litigation	____Disability	☐ Physician Office Notes	☐ Cardiology/EKG Reports
____Insurance	____Work Comp	☐ Immunizations	☐ Lab/Path Reports
____Self/Personal Copy	____Other	☐ Operative/Procedure Reports	☐ Radiology/Xray/MRI Reports
____Transfer or Continuity of Care		☐ Other: _____	☐ 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 _____