



VIRGINIA
WOMEN'S CENTER

Medical Records Request

I hereby request that the following medical records:

All Records: _____

Other, please specify: _____

be released from:

Dr. _____

Address: _____

and sent to the following physician

Dr. _____

at the Virginia Women's Center location checked below:

St. Mary's MOB, South
5875 Bremono Road, Suite 400
Richmond, VA 23226
Attn: Medical Records
Fax # 804-282-2601
Phone # 804-288-4084

Henrico Doctors' Professional Bldg
7611 Forest Avenue, Suite 200
Richmond, VA 23229
Attn: Medical Records
Fax # 804-288-3567
Phone # 804-288-4084

Memorial Regional Medical Ctr. MOB II
8266 Atlee Rd, #330
Mechanicsville, VA 23116
Attn: Medical Records
Fax # 804-559-2046
Phone # 804-288-4084

Kilmarnock Office
102 DMV Drive
Kilmarnock, VA 22482
Attn: Medical Records
Fax # 804-433-2392
Phone # 804-288-4084

John Rolfe Commons
2240 John Rolfe Parkway
Richmond, VA 23233
Attn: Medical Records
Fax # 804-545-9548
Phone # 804-288-4084

I understand that this authorization will be valid for 6 months.

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Virginia Women's Center has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to Virginia Women's Center at the address checked above.

Patient's Signature _____ Printed Name _____

Date _____ Date Last Seen in Office _____

Social Security Number: _____ - _____ - _____ Date of Birth ____/____/____

Reason for Transfer _____

Office Use Only
 OB
 GYN