

431 Park Avenue  
Suite 300  
Falls Church, VA 22046  
Phone: 703-528-6300  
Fax: 833-438-5538



1875 Campus Commons  
Dr.  
Suite 110  
Reston, VA 20191  
Phone: 703-437-8080  
Fax: 833-438-5539

**REQUEST FOR RECORDS TO HEALTHCARE FOR WOMEN**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City, State, Zip:** \_\_\_\_\_

I hereby request and authorize:

Name of Physician: \_\_\_\_\_  
Name of Practice (optional): \_\_\_\_\_  
Address of Physician: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To Release the following medical records to:

**Healthcare For Women P.C.**  
**431 Park Avenue, Suite 300**  
**Falls Church, VA 22046**  
**703-528-6300**  
**Fax: 833-438-5538**

- \_\_\_ All Medical Records
- \_\_\_ Office Notes (Please specify dates): \_\_\_\_\_
- \_\_\_ Lab/Pathology Results
- \_\_\_ Pap Smear Results
- \_\_\_ Radiology Results (Please specify dates): \_\_\_\_\_
- \_\_\_ Operative Reports
- \_\_\_ Other: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Office Use Only:**

Date Received: \_\_\_\_\_  
Date Faxed: \_\_\_\_\_  
Employee Initials: \_\_\_\_\_