



5388 Twin Hickory Road, Suite 102, Glen Allen Road, VA 23059

Fax : 888 -275-1128
Contact : (804) 396-6753
www.rvaphysicaltherapy.com

Release of Medical Information Request

Date: _____

Patient Name: _____

Date of Birth: _____ Date of Service: _____

Information to be released to: _____ Fax: _____

Information Requested (check all that apply):

_____ Patient's Entire Medical Record

_____ H&P and/or Consultation note

_____ Progress Notes for the last _____ visits / months

_____ Discharge Summary

_____ Lab Results

_____ X-ray Results

_____ Procedure Notes

_____ Operative Summary

_____ Other: _____

I hereby request that the above information be provided to the person or business listed.

Signature of Patient/Requestor*

Please print Full Legal name

*If signed by someone other than the patient, please provide the following information:

Name of Requester Relationship to Patient