REQUEST FOR MEDICAL RECORDS

DATE OF REQUEST: ____

PATIENT INFORMATION

Patient Name (Print):			
Patient Identification:	Social Security No.	Date of Birth	Medical Record
Reason for Request:			

SEND THE FOLLOWING RECORDS/REPORTS (Dates):__All until Present_____

- ☐ All Mary Washington Healthcare records
- ☐ All Gaertner Psychiatric Records
- ☐ Other:

SEND SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Name:	Kairos Counseling
Address:	308 Wolfe St Fredericksburg, VA 22407
Telephone:	540-370-6983 Fax: 540-427-7912

I, (Patient Print Name) ____, hereby request and authorize any and all medical records to be photocopied, released and mailed/faxed to the indicated address above for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) applies to my medical records and my protected health information. I expect the holder of my medical records to mail or fax my specified medical records as soon as reasonably possible by __14 Days__, not to exceed 30 days, unless my records are off-site which allows for an additional 30 days. This authorization may be revoked by me, at any time, by notifying Kairos Counseling of this revocation in writing. I have been advised that if I chose to not authorize that I will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payments.

☐ I HAVE NO PROTECTED HEALTH INFORMATION FOR THE SPECIFIED TIME FRAME release all my medical records that have been indicated above.

☐ I HAVE PROTECTED HEALTH INFORMATION WITHIN THE AUTHORIZED TIME FRAME release all the above medical records for the specified time frame except for the following ____________________
____

Signature of Patient: ____ Date: ___________________

Expiration Date for this Authorization: ________________________________