

**FAMILY PHYSICIANS OF ARLINGTON
103 W. BROAD STREET, SUITE 120
FALLS CHURCH, VA 22046
703-538-3444**

Authorization to Transfer Medical Records

Date: _____

Patient Name: _____

D.O.B: _____

SS#: _____

Address: _____

Phone #: _____

I hereby authorize Family Physicians of Arlington to release a copy of my medical records to:

Mail to Patient's Address

Mail to Doctor's Address (enter name and address):

Please Note: Original records will be securely archived for the next 6 years, or until minor patients reach the age of 18 as required by Virginia law. Original records cannot be released.

Patient Signature: _____

Date: _____

Payment: \$45

Date: _____

Credit Card (We will call for information)

Check

Cash