PINNACLE FAMILY PRACTICE

13135 Lee Jackson Memorial Hwy #202; Fairfax, VA 22033; Ph 703-429-2901; Fax 703-429-2902

Request for Release of Medical records from another practice TO Pinnacle Family Practice, LLC

Please print clearly

Patient Name:_____ Date of Birth:_____

SS#:_____ Phone#_____

Address:_____

_____

I hereby request my records be RELEASED TO:	**Office/Doctor to be releasing information:**
Pinnacle Family Practice, LLC	Doctor/ Practice Name:_____
13135 Lee Jackson Memorial Hwy #202	Office Phone #_____
Fairfax, VA 22033	Office Fax #:_____
Fax 703-429-2902	

Information to be released: ( ) All Records ( ) Visits ( ) shot record ( ) radiology reports ( ) EKG ( ) Labs ( ) Other:_____

(if desired you must specifically list HIV and STD testing also)

Reason for your request:

_____ Moving
_____ Unhappy with our practice
_____ Car accident related purposes
_____ Employer's request/needs
_____ Sports needs
_____ Changing physicians
_____ Legal reasons (You have an attorney)
_____ Life insurance purposes
_____ Seeing a specialist physician
_____ Continuing of care with my PCP

******* ATTENTION RELEASING OFFICE: *******

If you have a fee associated with the release of copies of these records that is more than $10 (Ten Dollars), please call the requesting patient or guardian at their above provided phone number and discuss your fee.

By signing this form below, I understand and agree that this authorization can only be revoked in writing by me (the patient) or legal guardian for patients under age of eighteen.
I also understand and agree that Pinnacle Family Practice, LLC is not responsible for any fees related to obtaining any copies of prior medical records

Patient/Guardian signature: _____ Date: _____

Print name if other than patient:_____