Gastroenterology Center of Northern Virginia, LTD.

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MEDICAL RECORDS REQUEST

Date:_____ Doctor:_____

Patient Name:_____ DOB: _____Phone Number:_____

Records requested from our office:

- ☐ **Entire record (copying fee of up to $30)**
- ☐ **Colonoscopy, EGD report(s)_____**
- ☐ **X-ray reports:_____**
- ☐ **Blood test results: _____**
- ☐ **Other:_____**

Reason for requesting records:

- ☐ **My personal records**
- ☐ **To give to my other doctor(s)**
- ☐ **Another doctor's appointment with:_____**
- ☐ **Transferring my care to another doctor**
- ☐ **Moving**
- ☐ **Other:_____**

Signature:_____ Date:_____

- ☐ **I will pick up my records**
- ☐ **Mail my records to me (addressed envelope attached)**

WE RECOMMEND KEEPING A COPY FOR YOURSELF, AS DUPLICATE REQUESTS WILL INCUR A CHARGE