GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA, LTD.

□ 1715 N. George Mason Dr. Suite 204
Arlington, VA 22205
Ph: (703)522-7476
Fax: (703)528-4209

□ 3200 Woodburn Rd Suite 220
Annandale, VA 22003
Ph: (703)560-6106
Fax: (703-204-1968

MEDICAL RECORDS REQUEST

DATE: _____DOCTOR: _____

PATIENT NAME: _____DOB:___/___/___

PHONE NUMBER: _____

RECORDS REQUESTED FROM OUR OFFICE:

 ENTIRE RECORDS: (COPYING FEE OF UP TO $30.00)

 COLONOSCOPY, EGD REPORT_____

 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