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Medical Records Release From About GYN, PLLC / Lillian M. DeCosimo, M.D.

FROM:

Patient's Name: _____
Date of Birth: _____
Date of Request: _____
Address: _____
City: _____ State: Zip: _____

RELEASE TO:

I hereby authorize the release of copies of my results from blood tests, radiology, pathology or:
(Specify type of records): _____

and request that they be forwarded to: Myself Entity listed below:

Name: _____
Address: _____
Signature: _____ Date: _____

NOTICE

We require a fee for copying and handling. Our fee is in accordance with Virginia law (*Section 8.01-413, 32.1-127, 1.03 and 54.1-2403.3 of the Virginia Code.*)

Handling: **\$10.00**

Total number of pages _____
\$0.50 per page up to 50 pages : _____ pages = \$ _____
\$0.25 per page thereafter: _____ pages = \$ _____

Total fee: \$ _____

Please be advised that it takes up to 15 business days to complete your request. If you require your records in less than 15 business days, we require an emergency processing fee of \$25, in addition to the regular fee. Your request will be then be completed within 2 business days.

For office use: Mailed Faxed Picked up by patient

Request processed by: _____ Date: _____