



# Virginia Foot & Ankle Surgical Associates

Medicine • Trauma • Reconstructive Surgery

## PATIENT REQUEST FOR MEDICAL RECORDS OR OTHER PROTECTED HEALTH INFORMATION (PHI) TO BE RELEASED TO OUR OFFICE.

To: \_\_\_\_\_  
(name of facility/physician to release the information)

Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Pt #: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**I hereby request that a copy of my medical records or other recorded Protected Health Information (PHI) as designated below be released to Virginia Foot & Ankle Surgical Associates.**

Office Notes

Diagnostic Test Results

X-rays

Other \_\_\_\_\_

**My requested mode of delivery of this documentation is:**

Fax to (434) 977-8083

I will pick up the documentation

\_\_\_\_\_  
Signature of Patient or Legal Representative)

\_\_\_\_\_  
Date

**This information was faxed to the above facility by:**

\_\_\_\_\_  
VFASA Staff Member

\_\_\_\_\_  
Date & Time Faxed



Center of Excellence in Lower Extremity Reconstruction & Trauma