



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:

Staff Member

VFASA

Date



Center of Excellence in Lower Extremity Reconstruction & Trauma