Fern L. Grapin, M.D.
2871 Duke Street
Alexandria, VA 22314
Office: (703) 751-3031
Fax: (703) 778-5999

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Patients Name: _____

Patients Address: _____

_____

_____

Date of Birth: _____

I hereby authorize you to release my Protected Health Information (PHI) in the form of medical records and any information including the diagnosis and records of any treatment, surgeries or examination rendered to me during the period from
_____ to _____.

What records do you want sent? _____

Release To: _____

_____

_____

Fax: _____

Reason for the request: _____

_____

Patients signature: _____

Who provided the information (in office): _____