Request for Medical Records
P.O. Box 25005
Richmond, VA 23260

Today's Date: _____

Please accept this written request for the transfer of medical records for my child named below.

Name: _____ DOB: _____

I understand that the medical records have been archived and must be retrieved from deep storage in order to complete my request. I understand that the retrieval fee, which includes archive search, retrieval, copying and delivery of said records to the recipient specified below is $100. I authorize that I am the parent or legal guardian of the patient named above and am entitled by law to request these records.

Physician/Office or Person Receiving Records _____

Address _____

City/State/Zip _____

Physician Fax Number **(_____)_____**

Office Phone Number **(_____)_____**

Requesting Parent/Guardian Phone Number (_____) _____

I understand the named entity listed above will receive my child's medical records within thirty business days from the date this request is received in a manner compliant with HIPPA legislation as specified by Virginia statute. I understand I will be contacted by phone to provide payment for the records retrieval and copying if I have not included a check for $100 with this written request.

_____

(Parent/Legal Guardian)