National Vascular Associates

Medical Records Request

Patient Name:_____DOB:_____
Address:_____

Phone:_____Email:_____

Release Information to:

Name/Facility:_____ Attention:_____

Address:_____

Phone:_____ Fax:_____

Purpose of Request: ☐ Referral from NVA to another Provider/Facility ☐ Personal Records

☐Second Opinion or Transfer of Care ☐Other_____

Information to be Released: ☐Office Notes ☐X-Ray/Radiology ☐ Lab/Path records ☐Op Notes

☐Entire Chart ☐Other (describe)_____

Specify date range:_____

Payment Options: Check, Cash or Credit Card

Charges outlined will be applied for all copies released directly to the patient. **Invoice must be paid before records will be released.

All fees are based on Code of Virginia

(Code of VA §8.01-413 Applies)

- Pages 1-50 = $0.37 each page
- Pages 51 & above = $0.18 each page

Plus $20 for handling fees

Patient Signature:_____Date:_____

Signature of Parent/Legal Guardian: _____Date:_____

This authorization will expire 1 year from the date appearing above. I understand that I may revoke this authorization at any time by notifying NVA in writing.