Request for Copies of Medical Records

The patient or authorized representative completing this form requests a copy of his or her medical records as maintained by Plastic Surgery Associates of Tidewater.

_____
Patient's Name

_____
Patient's Date of Birth

Would you like to pick up the copies at Centurion Document Management? ___Yes or ___No

I**f not, would you like the copies to be sent to directly to you or to another physician?**

___ I would like the copies to be sent directly to me at this address:

Street Address	Apt. #	City	State	ZIP Code

OR

__ I would like the copies to be sent to the physician identified below

_____
Name of Practice or Practitioner to Receive Records

Street Address	Suite #	City	State	ZIP Code

I authorize copies of the referenced medical records to be

_____ _____
Signature of Patient or Authorized Representative Date

_____
Telephone Number

If the person signing above is the patient's authorized representative, complete the line below.

_____ _____
Name of Authorized Representative Relationship to Patient

Please indicate if you would like to pick up the records at Centurion Document Management (address below) or would like the records to be mailed.

Centurion Document Management
1431 Baker Road, Suite C
Virginia Beach, VA 23455
Phone: 757.363.7400
Fax: 757.363.8379

Costs are as follows:
Copy of paper medical records: $22.00
Postage (flat fee for mailing records): $9.00
Copies of any photographs: $15.00