

WOMEN'S WELLNESS & COSMETIC LASER CENTER OF LOUDOUN

RELEASE OF RECORDS

DATE _____

I hereby authorize you, _____, to release my medical records to:

Dr. Angela Bess
Women's Wellness & Cosmetic Laser Center of Loudoun
19450 Deerfield Ave. TEL (703) 726-9680
Suite 445 FAX (703) 726-9780
Lansdowne, VA 20176

Please include all records including notes, lab results, sonograms, mammograms, or any diagnosis and treatment of any condition I have/had during the period from _____ to _____.

PATIENT SIGNATURE

WITNESS

PRINTED NAME

ADDRESS

DATE OF BIRTH

FEES FOR COPYING MEDICAL RECORDS:

- 1) If records are being sent directly to another provider's office, there will be no charge.
- 2) If patient is requesting records for personal, life insurance applications, school physicals, work physicals or any other reason, a fee of 0.37 cents per page will be charged.

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