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.