ALLPHASES DERMATOLOGY, LLC
6355 Walker Lane, Suite 311
Alexandria, VA 22310
Phone: 703-822-0222
Fax: 703-977-2814

I, _____, hereby authorize with this medical release form to have all my medical records to be faxed to the provider indicated below.

_____ _____
Print Full Name Date of Birth

_____ _____
Signature Date

_____
Relation to Patient

According to Virginia Code 8.01-413, fees for medical records are $10 administration fee and $0.50 per page for the first 50 pages, and $0.25 for each page thereafter.

Medical records Charge: _____ $10 administration fee

_____ pages @ $0.50 per page _____

_____ pages @ $0.25 per page _____

TOTAL AMOUNT DUE: **_____**

PLEASE REMIT PAYMENT – UPON RECEIPT RECORDS WILL BE SENT.

PLEASE ALLOW 10-14 BUSINESS DAYS FOR RECORDS TO BE READY

Remit to: