1123 Heatherstone Dr. • Fredericksburg, VA 22407 • Phone: 540-899-2555 • Fax: 540-899-3554
Claudia Sussdorf, M.D.
Jacinta White Topps, M.D.
Sita Canady, M.D.

MEDICAL RECORDS REQUEST

When requesting an entire medical record hand-carried copy or transfer, all medical records will be released; to include any correspondence from outside doctor's offices. You may revoke this request to our office, in writing, at any time. This signed release will expire one year from the date written at the bottom of this page.

Medical records are transferred to other medical facilities via postal mail, or sent via fax if under a total of 50 pages. Hand-carried medical records will be charged a handling fee.

Please note: we have a storage facility that stores inactive and over 18 files. If your file must be requested, there will be a retrieval fee.

Please check the appropriate box below if payment is required:

☐ Charge for individual record - $20.00

☐ Charge for family (2 or more) - $40.00

☐ Charge for retrieval from storage facility - $30.00

**** Please allow 5-7 business days for medical records to be copied****

Patient Name: _____ Date of Birth: _____

Please specify which information you would like our office to release:

- Entire Medical Record
- Immunization Record
- Physical
- Labs/Radiology
- Other: _____

TRANSFER MEDICAL RECORDS FROM:

Physician/Office Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

TRANSFER MEDICAL RECORDS TO:

Physician/Office Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

I acknowledge that patient medical records may include personal information, such as: drug or alcohol abuse, psychiatric evaluations, HIV testing, etc. I understand that my signature on this medical request form is my affirmation that I have read, agree to, and understand all of the terms stated herein, and that I acknowledge that by signing below, I am providing Fall Hill Pediatrics my full consent to have the above requested medical records copied and transferred to the appropriate medical facilities and/or physicians listed herein.

Parent/Guardian/Patient Signature: _____ Date: _____

Relationship to Patient: _____ (mm/dd/yyy)