Requesting medical records for patients of Dr. Chopivsky

To obtain your medical records;

1) Complete the request for medical records. Complete one entry per person; don't forget your own records if you are requesting for your family;
2) Read and sign the release form indicating your legal authority to acquire the records;
3) Complete the Credit Card Authorization;
4) That's it!

Fax all the items above to (703) 726-0081 along with copies of your identification documents (refer to the release form for a list of acceptable identification documents).

Once we get your request and have located your records, you will receive a call from us to let you know you can come collect them. Alternatively, we can mail you the records subject to a small handling fee.

Please note: Although we maintain these records in our facility, you are not considered a patient here until you register with us. As such, your records as delivered to us have never been inspected and your confidentiality has been maintained.

Sincerely,

Family Medicine at Lansdowne
19450 Deerfield Ave., Suite 265
Leesburg, VA 20176

Tel (703) 726-8687
Fax (703) 726-0081

September 2010

Request for medical records

Requestor:

Last name: First name:	Date of Birth *(MM/DD/YYYY)*
Relationship to requestor: ☐ Spouse, ☐ Child, ☐ Parent, ☐Other __________________	☐Male ☐ Female
Identification Documentation *(Name / Issuing Authority / Number)* ►	Expiration Date: ►
Signature: *(not required for dependent child under 18 years)*	Date:
By providing copies of my identification documentation and by signing above, I am authorizing Family Medicine at Lansdowne to give my medical records to "Requestor" listed above.	

Additional person:

Last name: First name:	Date of Birth *(MM/DD/YYYY)*
Relationship to requestor: ☐ Spouse, ☐ Child, ☐ Parent, ☐Other __________________	☐Male ☐ Female
Identification Documentation *(Name / Issuing Authority / Number)* ►	Expiration Date: ►
Signature: *(not required for dependent child under 18 years)*	Date:
By providing copies of my identification documentation and by signing above, I am authorizing Family Medicine at Lansdowne to give my medical records to "Requestor" listed above.	

Additional person:

Last name: First name:	Date of Birth *(MM/DD/YYYY)*
Relationship to requestor: ☐ Spouse, ☐ Child, ☐ Parent, ☐Other __________________	☐Male ☐ Female
Identification Documentation *(Name / Issuing Authority / Number)* ►	Expiration Date: ►
Signature: *(not required for dependent child under 18 years)*	Date:
By providing copies of my identification documentation and by signing above, I am authorizing Family Medicine at Lansdowne to give my medical records to "Requestor" listed above.	

Additional person:

Last name: First name:	Date of Birth *(MM/DD/YYYY)*
Relationship to requestor: ☐ Spouse, ☐ Child, ☐ Parent, ☐Other __________________	☐Male ☐ Female
Identification Documentation *(Name / Issuing Authority / Number)* ►	Expiration Date: ►
Signature: *(not required for dependent child under 18 years)*	Date:
By providing copies of my identification documentation and by signing above, I am authorizing Family Medicine at Lansdowne to give my medical records to "Requestor" listed above.	

Please use additional copies as needed for additional family members.

Medical Records Release Form

Purpose

By completing this form, you represent your legal authority to obtain the information in the records you are requesting. If you do not agree, or you are not sure of anything asked of you on this form, do not signed the form. By completing, signing and submitting this form to us you warrant that the information you have provided is true and may be relied upon to provide you with the services you are requesting. You further represent that you have full legal authority to request these records. You are cautioned that making false statements to obtain or assisting others in obtaining another's medical records without proper authority may be a felony. Please remember to print clearly.

Acceptable identification documents?

To identify you, we require that you provide use with an acceptable form of identification. Below is a list of acceptable forms of identification. Other forms may be acceptable upon request. Generally any unexpired US government issued photo ID will suffice as proof of identify, along with a traceable document which includes your address. You should bring these items with you when you collect the records.

List of acceptable identification documents. Originals only please.

Unexpired drivers license with current address
Unexpired US passport and recent utility bill in your name
Government issued job ID plus credit card statement

The person requesting the records

The person actually requesting the records must complete the information below. If you wish to collect records in-person, you will need to bring in your original identification documents. If you would prefer, we will mail records to you for additional fees; however, the mailing address must match your identification documents. If your mailing address does not match that on your ID, you will need to pick up the records in person. We use the name and address on your identification document(s) to ship your records to you.

Legal name (first, last) of person making request	Date of Birth (MM/DD/YYYY)	Social Security #
Address of record	Identification Documentation	
City, State & Zip	Identification Documentation #	
Daytime telephone number (in case we need to contact you)	Id Documentation Expiration Date	

In requesting my medical records ("Records"), I hereby forever hold harmless StatHealth Medical Centers, Inc d/b/a Family Medicine at Lansdowne and Dr. Robert Saunders (collectively or individually "Company") for any findings whether now known or unknown, medical or financial, under any theory of Law practiced or otherwise that may be contained within such Records. I acknowledge that Company has no knowledge of any content of such Records having not been afforded an opportunity to examine them and that no physician-patient relationship exists now nor has existed previously.

I acknowledge Company has offered to accept responsibility for my continuing medical care in its ordinary course of business without condition and without examination of Records and that I expressly decline such offer.

I accept responsibility as custodian the care of Records being provided to me and shall provide them to the medical provider of my choice. I understand that I am receiving original copies and that no duplicates shall be retained by Company for any purpose. Should these records be misplaced, I understand that they can not be reproduced.

My signature below affirms my legal authority to request the medical records of the individuals whose names I have provided and my acceptance of the terms listed above.

► ______________________________ ► ______________

Signature of person requesting records (must be over 18) — Date

Request for medical records

Payment Page

We make a small charge to help cover the cost of storage, staff time required to locate and pack records and the shipping charges we incur to get them to you conveniently. We require a credit card at the time you place your request to charge for these items.

Fee to locate records

Locate one record	$15
Locate one to four records	$20
Locate five or more records	$25

How would you like us to get the records to you (select one)?

Office pickup in-person ( )	No additional charge (must be scheduled)
Registered US Mail signature rcpt ( )	$10 + postage
FedEX 2 day ( )	$10 + FedEx charge by weight

Credit Card Number:

Expiration Date

CVV (3 or 4 digits)

I authorize a charge to my account for the services rendered. Charges will not be billed until records are shipped. If my records are not located, I understand no charge will be made. I understand and assume the risk of delivery by the method indicated. I promise to pay Card Issuer total amount indicated according to card issuer Agreement. I understand refunds will not be made after records are shipped.

Authorized Signature ____________________ Date

NOTES:

- All records will be shipped to same physical address;
- Funds will be withdrawn the day the records are shipped.
- Billing address for credit card must match shipping address.
- Your Credit Card statement will show a charge from:
  StatHealth Medical Centers, Inc. d/b/a Family Medicine at Lansdowne

Family Medicine at Lansdowne
19450 Deerfield Ave., Suite 265
Leesburg, VA 20176-6821
Tel (703) 726-8687 FAX (703) 726-0081