Galaria Plastic Surgery & Dermatology, PLC
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P)703-327-3173 F)703-327-1743

Record Request Authorization

Records Are To Be Retrieved From: Galaria Plastic Surgery & Dermatology, PLC
Records Are To Be Sent To:
Name of Location: ____
Address: ____
____
Phone Number: ____________________________Fax Number: ________________________________
Patient Information:
Patient's Name: ____ DOB: _______________
Address:____
____
Phone: ____

I do hereby consent and authorize you to release copies of my medical records. I understand this authorization includes consent for the release of alcohol, drug, psychiatric, and psychological information; any information relating to pregnancy, sexually transmitted diseases, HIV Testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original. Please send copies of all restricted information as soon as possible to the address listed.

It may take up to 5-7 business days to process my request. Charts sent to other doctors offices will be sent at no charge but we reserve the right to charge $10.00 for charts requested for personal use.

□ All Clinical Medical Records
□ Specific Date: From ___________________________ To_________________________________
□ Partial Records – Please list (e.g. pathology, photographs, etc.) __________________________________
I prefer to have my records: □ Faxed □ Mailed □ Picked up
Note: Charts over 20 pages will not be faxed

Patient's Signature _______________________________________ Date____________________________

Provider Signature _______________________________________ Date ___________________________