Galaria Plastic Surgery & Dermatology, PLC
24805 Pinebrook Road, Suite 105 Chantilly, VA 20152
22895 Brambleton Plz, Suite 200, Ashburn, VA 20148
P)703-327-3173 F)703-327-1743

Record Request Authorization

Records Are To Be Retrieved From:

Name of Practice: ____

Address:____

____

Phone Number: _________________________________Fax Number: ___________________________

Patient Information:

Patient's Name: ____ DOB: ____________________

Address:____

____

Phone number: ____

Records Are To Be Sent To:

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

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.

□ 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

Patient's Signature ____ Date____________________

Provider Signature ____ Date ___________________