ATLANTIC BRAIN & SPINE

Jae Y. Lim, M.D.

Medical Records Release Request Form

Please allow up to 7 days for processing

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Daytime Phone Number: _____

☐ **I would like a copy of my medical records:**

☐ Pick-up in the office (Our office will contact you once your record is ready)

☐ Fax: _____ Attn: _____

☐ Mail: Address: _____

City: _____ State: _____ Zip: _____

☐ **I hereby request my medical records be released and submitted TO:**

Physician or Institution's Name(s) Address Phone & Fax Number

_____

_____

_____

_____

Information to be released:

☐ Office Notes ☐ Operative Reports ☐ Pathology Reports

☐ Radiology Reports ☐ Procedure Notes ☐ Other: _____

I, the undersigned, request and authorize Atlantic Brain & Spine to release the medical information to mentioned above. I understand that if the person or agency that receives my information is not a healthcare provider or health plan covered by the HIPAA privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations.

_____ _____

Patient or Authorized Representative Signature Date

**This authorization will expire in one year from the date signed*

Mail or Fax completed form to:

Atlantic Brain & Spine
8501 Arlington Blvd. Suite #330
Fairfax, VA 22031
Fax: (703) 876-4276