Nova Group for Woman
Drs. Andersen & Maanavi, M.D., Ltd.
8501 Arlington Blvd, Suite 300
Fairfax, Virginia 22031
703-560-1611
Fax: 703-573-0217

AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL RECORD INFORMATION

Patients Name: ______________________________ Today's Date: ________________________

Birthdate: ______________________Soc. Sec. #_____________________Phone:___________________

Address: _______________________City:______________________State:_________Zip:___________

TO (RECORDS TO BE RELASED TO: FROM (RECORDS BEING RELEASED FROM:

Name: _____________________________________ Name: __________________________________

Address: ___________________________________ Address: __________________________________

City/State/Zip: ______________________________ City/State/Zip: ______________________________

Phone: ____________________________________ Fax: _____________________________________

Please send the following information:

□ Progress Notes
□ Lab Results/pathology reports
□ Radiology Reports Ordered by our facility
□ Recent office visit notes/procedure notes
□ Pap smear Results Only
□ All Medical Records for Past Three (3) Years
□ Operative Reports

For the purpose of: □ Transfer of Care □ Second Opinion □ Legal □ Insurance
□Other:____

I am aware that my medical record may contain the following and I further authorize the release of that information.

□ Alcohol/Drug use or abuse
□ Mental Illness/social service communication
□ History or treatment for venereal disease
□ Testing or treatment for HIV/AIDs or Hepatitis

This authorization shall expire one (1) year from the date signed and can be revoked at any time in writing provided that information has not yet been released.

Our office charges for the processing of medical records in accordance with Va. Code 8.01 -413.

PLEASE DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM.

PATIENT'S NAME: ____

PATIENTS SIGNATURE: ______________________________ DATE: _________________________

PARENT (Patients Under 16 years old) OR LEGAL GUARDIAN NAME: _________________________

PARENT OR LEGAL GUARDIAN SIGNATURE___________________________DATE___________
RELATIONSHIP TO THE PATIENT: ____

Signature Verified___________ Processing Fee: _____________Processed Date: _________________
Staff Name: _______________________ Noted in Log Book: __________________________________