VIRGINIA PEDIATRIC GROUP, LTD

I HEREBY REQUEST A COPY OF MEDICAL RECORDS FOR:

PATIENT NAME_____DATE OF BIRTH_____

PATIENT NAME_____DATE OF BIRTH_____

PATIENT NAME_____DATE OF BIRTH_____

PLEASE SEND MEDICAL RECORDS TO / FROM:

☐ FAIRFAX OFFICE	☐ HERNDON OFFICE	☐ GREAT FALLS OFFICE	☐ SOUTH RIDING OFFICE
8316 ARLINGTON BLVD	131 ELDEN STREET	737 WALKER ROAD	25055 RIDING PLAZA
SUITE 300	SUITE 312	SUITE 4	SUITE 290
FAIRFAX, VA 22031	HERNDON, VA 20170	GREAT FALLS, VA 22066	SOUTH RIDING, VA 20152

REASON FOR TRANSFER:

Relocation _____

Change of Insurance _____

Other _____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP TO PATIENT DATE

CURRENT PHONE NUMBER OF RESPONISBLE PARTY EMAIL ADDRESS

FEE:

EMAIL: $25.00/CHART ☐

COMPACT DISC: $30.00/CHART via USPS First-Class mail ☐

TYPE OF CREDIT CARD:

_____

CREDIT CARD NUMBER EXP. DATE

_____

NAME ON CARD

_____

ADDRESS OF CARD HOLDER

SIGNATURE OF CARD HOLDER DATE