CFA
COLUMBIA FERTILITY ASSOCIATES

MEDICAL RECORDS RELEASE FORM

Patient Name:_____ **Date of Birth:**_____

Address:_____

Phone Number (Daytime):_____ **(Evening):**_____

I request and authorize CFA to release the following healthcare information:_____

_____

Specified Dates of Service:_____

I will pick my records up ☐

Mail requested records to: _____

_____

_____

_____

Fax requested records to: _____

Include name and fax number of recipient

I understand the fee for copying or faxing records is 50 cents per page. If the records are mailed, the cost of postage will be added. A $25.00 service charge will be applied to records stored offsite.

It may take 5-7 business days to process your request.

Patient's Signature: _____ **Date:**_____

Spouse/Partner Signature: _____ **Date:**_____

(Required if their records are included the request)

2440 M Street, NW
Washington, DC 20037
Ph: 202-293-6567 Fax: 202-778-6190

10215 Fernwood Road
Bethesda, MD 20817
Ph: 301-897-8850 Fax: 301-897-8040

1005 N. Glebe Road
Arlington, VA 22201
Ph: 703-525-4776 Fax: 703-525-8013