Northern Virginia Internal Medicine & Pediatrics, P.C.

SPECIALIST FOR ADULTS. SPECIALIST FOR KIDS.
CARE FOR THE ENTIRE FAMILY.
MARY ELLEN GALLAGHER, M.D.
2501 N. Glebe Road, Suite 301
Arlington, VA 22207
703.527.6664
Fax 703.527.0655

Authorization to Release Medical Records

Date: _____

To (Doctor's Name and Address):

_____

_____

Phone #_____**Fax #** _____

Patient Name: _____

Date of Birth: _____

Address: _____

_____

Phone Number: _____

I hereby authorize you to use, release and/or disclose a copy of my medical records and protected health information to:

Please **FAX** all records to **(703) 527-0655**
If **NOT** able to **FAX** then send records via mail to:
Dr. Mary Ellen Gallagher, M.D.
2501 North Glebe Road, Suite 301
Arlington, VA 22207

Records/Information to Be Released:
[ ] All records **[ ] Chart notes for office visits from date of** _____
[ ] Lab results from date of _____ **[ ] Operative/pathology reports from date of** _____
[ ] Other _____

- I understand that I may revoke/cancel this authorization at any time by giving written notice of my decision to do so.
- I understand that once my records are released that they will no longer be within your control and could potentially be re-released or re-disclosed by the recipient.
- I understand there may be a cost for photocopying, handling and mailing of my records
- This authorization will expire 90 days from the date on this form after which it will no longer be valid

Patient Signature (if over 18): _____
Parent/Guardian Signature (if patient under 18): _____
Relationship to Patient: _____