TO REQUEST A COPY OF YOUR MEDICAL RECORDS FOR YOURSELF OR ANOTHER PROVIDER PLEASE COMPLETE THE FOLLOWING STEPS:

1. Complete the following Authorization to Release Medical Records in its entirety. Incomplete forms will not be processed and will delay your request. You will need to provide all phone, address and fax numbers accurately.

2. Return completed form by one of the following options:

*Before June 1, 2025*

Email scanned copy to secure@susankinkeadacreemd.net

Mail to 1485 Chain Bridge Rd, Suite 203, McLean, VA 22101

Fax to 703-992-6539

*After June 1, 2025*

Mail to 406 Colin Ln NW, Vienna, VA 22180

Fax to 703-319-1160

3. Upon receipt of your form, an invoice for the record processing fee will be emailed to you. (Medical record processing fees are in accordance with Virginia Code § 8.01-413). The invoice will include the following costs:

* $20 search and handling fee
* Copy fee: $0.50 per page for pages 1-50; $0.25 per page thereafter
* Certified mail postage (if applicable)

4. Payments by credit card can be accepted before June 1, 2025. Payments by check can be mailed to one of the above addresses, as applicable.

3. Your records will be processed in 8-10 business days from the date your payment is received. Records can be sent either by fax or USPS certified mail.

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Patient Information:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recipient Information:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Susan Kinkead-Acree, MD to release my protected health information (including any substance-abuse-related treatment), as indicated on this form to the recipient listed below.

Recipient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery & Payment Information:

Please check one only: \_\_Fax \_\_USPS Mail (mandatory certified mail)

Description of the information to be disclosed (check all that apply):

* Initial psychiatric evaluation
* Progress notes (therapy notes included)
* Medication prescription history
* Telephone records
* Assessment questionnaires
* Lab test results
* Physician coordination-of-care correspondence

Acknowledgement of Processing Fees:

I hereby acknowledge that my protected health information will be released to the above-named facility or person after receipt of payment for processing, shipping and handling. I understand that an invoice for these fees will be sent to me directly at the above email address. I understand that once my payment is received, my records will be sent to the above-named facility or person in 8-10 business days.

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Patient signature Telephone number (required) Date