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 3020 HAMAKER CT SUITE 200 FAIRFAX, VA 22031	___ HERNDON OFFICE 131 ELDEN STREET SUITE 312 HERNDON, VA 20170	___ GREAT FALLS OFFICE 737 WALKER ROAD SUITE 4 GREAT FALLS, VA 22066	___SOUTH RIDING OFFICE 25055 RIDING PLAZA SUITE 290 SOUTH RIDING, VA 20152

REASON FOR TRANSFER:

Relocation _____

Change of Insurance _____

Other _____

_____
SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP TO PATIENT DATE

_____
CURRENT PHONE NUMBER OF RESPONSIBLE 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