Release of Medical Records Authorization Form

Attention: Release of Medical Records: ______________________________________

Please release the following information to____ Dr. Andrew Song / ____Dr. Kevin Choe

FAX TO: 571-665-6859

EXAM TYPE:	**DATE OF STUDY:**
PATHOLOGY REPORTS:	______________________
OPERATIVE REPORTS:	______________________
DISCHARGE SUMMARIES:	______________________
RADIOLOGY REPORTS:	______________________
OTHER:	______________________

PLEASE PRINT THE FOLLOWING

PATIENT NAME: ____

ADDRESS: ____

DOB: ____

PATIENT'S SIGNATURE: ____

Signature of authorized person to consent for patient: ________________________

What is your relationship to the patient? ___________________________________

2280 Opitz Boulevard, Suite 120, Woodbridge, Virginia 22191 | Phone:703.670.3349| Fax: 571.665.6859

PotomacRadiationOncology.com