GENETICS & IVF
Institute

REQUEST TO INSPECT OR COPY PATIENT'S MEDICAL RECORDS

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

Address: _____

Telephone: _____

Specify the records you would like to access:

❑ Medical records ❑ Billing records

❑ All of each type checked above

❑ All of each type checked above between the dates of _____ and _____

❑ Only records pertaining to _____

_____

_____

Specify how you would like to access the records:

❑ **Inspect at GIVF during office hours**

- You must call GIVF at 703-698-7355 to schedule your visit in advance so that we have your records and a private room available. Records may not be removed from GIVF, and copying services are not available.

❑ **Pick up a copy in person**

- Please call us at 703-698-7355 before you come to pick up your records to be sure they are ready.

❑ **Have a copy mailed to you at the address listed above**

If you are requesting inspection or pick-up at GIVF, you will be required to show photo ID before reviewing or receiving your records. If you are requesting a copy of your record, you may be charged the reasonable costs of copying and/or postage.

Patient or Legal Representative Signature:_____ **Date**: _____

If signed by legal representative: Evidence of legal representative's authority to sign this form must be provided to GIVF. Legal representative's relationship to patient: _____.

Completed forms may be submitted to GIVF by fax at 703-991-8030 or by mail to Genetics & IVF Institute, 3015 Williams Drive, Fairfax, VA 22031 Attn: Medical Records.

For GIVF use only:

Completed By: _____

Date Records Mailed/Picked up: _____ Fees for Copying and Mail: _____