The George Washington University
Medical Faculty Associates

2150 Pennsylvania Avenue, NW
ATTN: Medical Records
Washington, DC 20037
Telephone: 202.741.2768
Fax: 202-741-2405
Web: www.gwdocs.com

RECORD REQUEST FORM

I WISH TO: ☐ **MODIFY** ☐ **REVOKE** **Initial** _____ **Date** _____

1. I, hereby request that The George Washington University Medical Faculty Associates ("MFA") disclose the records identified in this request to the individuals/entities identified herein.

2. The purpose of this request for medical records is: (Check all that apply)

- ☐ I am moving and need to transfer my records to another health care provider.
- ☐ I am changing physicians.
- ☐ I am consulting with another physician and want him or her to review my record.
- ☐ I am seeking a second opinion.
- ☐ Other: _____
  (The timeframe and charges associated with this request will depend upon the purpose of your request.)
- ☐ I am exercising my right to a copy of my "designated record set" pursuant to MFA's Notice of Privacy Practices and/or 45 C.F.R. §164.524. MFA will charge you for the cost of copying and mailing (if applicable) the records and will provide you with your records within 30 days of receipt of this request. If the records are located offsite, it may take up to 60 days for us to provide you with access to these records. Notwithstanding the above, if your request is for mental health records and you received treatment in the District of Columbia, we will provide you with these records within 30 days of receipt of this request.

3. The records that I request be disclosed are described as follows (please list the name of the provider, department, date(s) of service, type of record and any other identifying information):

_____
_____

4. Please disclose the records identified herein to (please provide name and address):

_____
_____

5. I understand that I can revoke this authorization at any time, and that unless I revoke it sooner, it will automatically expire upon the disclosure made pursuant to this request. I recognize that any revocation that I make will not effect a disclosure that has already been made per this request.

6. I hereby release The George Washington University Medical Faculty Associates, and its employees, officers and physicians from any and all liability for the disclosure of personal health information made in accordance with this request, including any subsequent unauthorized disclosure(s) made by a recipient. I agree to pay any charges associated with the disclosure of records.

_____
Individual (Signature)

_____
Individual/Guardian/Legal Representative

_____
Print Name

_____
Print Name

_____
Date

_____
Relationship/Authority

_____
Social Security Number (Individual)

_____
Date of Birth (Individual)