MOUNT VERNON PRIMARY CARE ASSOCIATES
8101 HINSON FARM RD, SUITE 417
ALEXANDRIA, VA 22306
Telephone (703) 799-4000
Facsimile (703) 799-4569

Michael D. Lieberman, M.D.
Stephen W. Rex, M.D.
Sandy J. Robertson, M.D.
Patricia Adams, CANP
Ellen Hodges, CFNP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request that _____
Physician Name: Last, First

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Number **Fax Number**

Forward medical records (specify)_____for:

_____ ____/____/____
Patient Name **DOB**

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

For Dates: _____ to _____

TO: Mount Vernon Primary Care Associates
8101 Hinson Farm Rd. Suite 417
Alexandria, VA 22306
Fax: 703-799-4569

I hereby understand that by signing this form I am giving authorization to release information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Please send copies of all information including the diagnosis and records of treatment or examinations rendered to me.

Signed: _____ Witness: _____

Print Name: _____ Physician Requesting Records:

Date: _____ _____