Neurology & Acupuncture Clinic, PLC
Qingyan Zhu, MD

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of the following medical records:

First and Last Name _____ Date of Birth _____

Lab/X-ray results only Entire record (circle one)

From / To (circle one)

Neurology & Acupuncture Clinic
1520 Breezeport Way
Suite 600
Suffolk, VA 23435
(757) 638-3316
(757) 295-0859--Fax

From / To (circle one)

Physician/Practice Name: _____

Street Address: _____

City/State/Zip Code: _____

Phone Number (including area code): _____

_____
(Signature of patient, parent or legal guardian)* Date

***If patient is 18 years or older, the patient must sign**

_____
Phone (Day) (Home)

_____
Current Home Address

Notice to Patients requesting Medical Records

In the State of Virginia, the physician who creates the patient's medical record is the owner of those records. Current Virginia law states that a summary or photocopy of the medical record may be released to the patient or the patient's representative upon request in writing. (This form may be used for that purpose.)

Please note that the law allows the physician two weeks to comply with your request. It also permits the office to charge a reasonable fee for preparing records and photocopying.