Reston Pelvic
Surgery Associates

George Iskander, MD, MBA, FACOG

Medical Records Release Form

Patient Name:_____ DOB:_____

The information you may release subject to this authorization form is as follows:

Complete Records	History & Physical	Progress Notes	Lab Reports
Radiology Reports	Operative Reports	Pathology Reports	Treatment Record
Hospital Reports	Medication Records	Other (specify):_____	

Release my protected health information (PHI) to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:_____

Address:_____

City:_____ State:_____ Zipcode:_____

Phone:_____ Fax:_____ Email:_____

The purpose/reason for this release is as follows: _____

Send by (*circle one*): FAX EMAIL

Date:_____

Patient Name: _____

Patient Signature:_____

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