

Records Release Form TO Tepeyac Family Center

I hereby authorize the release of my medical records TO:

**Tepeyac Family Center
11135 Lee Highway
Fairfax, VA 22030
Phone: (703) 273-9440
Fax: (703) 273-9445**

Records for Treatment Date _____ to _____.

All records X-Ray/Sonogram reports Prenatal Reports
 Discharge Summary Operative Reports Lab Reports

To _____

Address _____

City _____ State _____ Zip _____

Office Telephone # _____ Fax # _____

Patient's Name _____

Signature of Patient or Legal Guardian _____

Date of Birth _____ Date of Request _____