StarCare Gynecology and Obstetrics, LLC

Records Transfer Request For Treatment Purposes

Date: _____/_____/_____

To: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the release of my medical records or copies of such and request that they be transferred to:

StarCare Gynecology and Obstetrics, LLC

3301 Woodburn Rd, Suite 102, Annandale, VA 22003
4208 Evergreen Ln, Suite 213, Annandale 22003
106 Elden St, Suite 13, Herndon, VA 20170

FAX: 703-698-8998

Patient's Name: _____

Patient's date of birth: ____/_____/_____ Social Security #_____

_____ _____/_____/_____
Signature of Patient/Guardian/Authorized Person Date

_____ _____
Please print name of signatory Relationship to patient