

RELEASE OF RECORDS FAX SHEET

DATE: _____

TO: **Person** _____**Organization** _____**Fax#** _____

FROM: Department Of Radiation Oncology
4320 Seminary Rd, Alexandria, VA 22304
Phone (703) 504-7900
Fax (703) 504-7979

MESSAGE: Request of Medical Records

The following patient was previously seen or treated at your facility:

Patient: _____ DOB: _____

Patient Signature: _____ **Date:** _____

Approximate Dates of Treatment: _____

Please provide us with the following*:

- Office Notes (Consultations, Follow-up, Treatment Summary)
- Pathology Report (s)
- Operative Reports (s)
- Radiology Report (s)
- Lab (s)
- Treatment plan report from treatment planning system
- Treatment plan beam's eye views and DRR's or simulation films
- Number of delivered fractions & prescribed dose per fraction
- Other: _____

* DICOM files (CT, Structure, Plan, Dose) are not required but are encouraged if possible. We accept CD, DVD, or USB Flash.

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