

RELEASE OF RECORDS FAX SHEET**DATE:** _____**TO: Person** _____**Organization** _____**Fax#** _____**FROM:** Department Of Radiation Oncology
44035 Riverside Parkway, Suite 100, Leesburg, VA 20176
Phone (703) 858-8850
Fax (703) 858-8870**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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