INOVA

Inova Dwight and Martha Schar Cancer Institute

Inova Loudoun Hospital

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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