Medical Release of Information

Drs. Wayne and Fred Shaia
10200 Three Chopt Rd
Henrico, VA 23233
Phone:804-288-3277 Fax: 804-282-1043

We are happy to maintain your records while you are an active patient. We can transfer your records to another health care provider should you wish to seek care elsewhere. We consider patients inactive if either they ask to have their records transferred or they have not been seen in our offices for six years. Our policy is to destroy inactive medical records in accordance with the Department of Health Professions regulations below:

Patient Name: _____

Address: _____

SSN#: _____ Birth Date: _____

Why are you requesting your records? _____

Circle the preferred method for receiving these records: Will pick up at our office USPS

Fax _____-_____-_____ email _____ (Not encrypted)

There is a flat administrative fee of $10 to complete this request and .50¢ per page for all printed pages (no per page fee for faxes or email delivery method). Please understand we do our best to complete these request in a very timely matter. However, all requests must be signed off by the doctor & we are bound by his scheduled. We should have your request completed within 5 working days.

Please check appropriate box

[ ] Above listed patient is giving the authorization for the Balance and Ear Center to send their Medical Records to:

Business Name: _____

Attn: _____

Address_____

City _____St _____ Zip_____

Phone _____ Fax _____

[ ] Above listed patient is giving the authorization for the facility listed below to send their Medical Records to the Balance and Ear Center, Inc.

Facility Name: _____Dr._____

Fax #: _____ Phone #: _____

Please fax the following medical records to Dr. Shaia at 804-282-1043

☐ Hearing Test ☐ Labs ☐ CT, MRI, Report ☐ Office Notes
☐ Sleep Study ☐ All Records ☐ Pathology Report ☐ CXR, EKG, Cardiac Clearance
☐ Other: _____

[ ] Above listed patient is giving permission for:

_____, who is my _____ to be able to speak with Fred T. Shaia, MD, or Wayne T. Shaia, MD about my medical condition and treatment.

_____ Date: _____
Patient's Signature

_____ Date: _____
Witness Signature